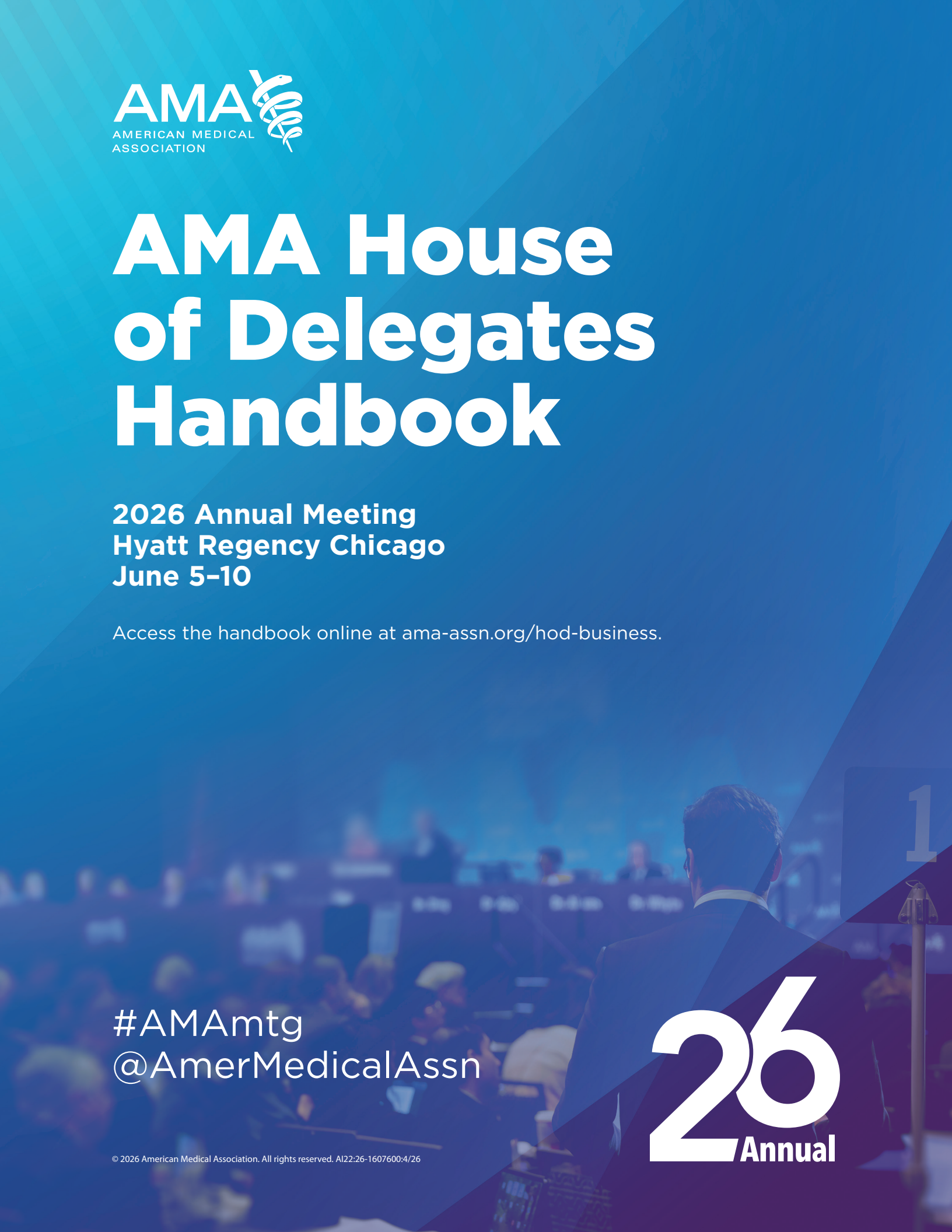
AMA
AMERICAN MEDICAL ASSOCIATION

AMA House of Delegates Handbook

2026 Annual Meeting
Hyatt Regency Chicago
June 5–10

Access the handbook online at ama-assn.org/hod-business.



#AMAmtg
@AmerMedicalAssn

26 Annual

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at https://policysearch.ama-assn.org/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (A-26)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Ethics and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, June 6, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles, and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   - **Officials of the Association and AMA Councils**
   - **Ex Officio Members of the HOD**
   - **SSS Representatives**
   - **Listing of Delegates and Alternate Delegates**

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - David H. Aizuss, MD, Chair**

01	Annual Report	F
02	New Specialty Organizations Representation in the House of Delegates	E&B
03	2025 Grants and Donations	Info. Report
04	AMA 2027 Dues	F
05	Update on Corporate Relationships	Info. Report
06	AMA Performance, Activities and Status in 2025	Info. Report
07	Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026	Info. Report

08	Council on Legislation Sunset Review of 2016 House Policies	B
09	American Medical Association Optimal Health Outcomes Annual Report	Info. Report
10	AMA Efforts on Medicare Payment Reform	Info. Report
11	AMA Public Health Strategy Update	Info. Report
12	The Uniform Health-Care Decisions Act	B
13	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes	B
14	Binding Arbitration in Health Insurance Contracts	B
15	Protecting the Prescriptive Authority of Plenary Licensed Physicians	B
16	Demographic Report of the House of Delegates and AMA Membership	Info. Report
17	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report	D
18	Report on the Preservation of Independent Medical Practice	Info. Report
19	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	B
20	Mitigating the Impact of Excessive Prior Authorization Processes	G
21	Abolishing Venue Shopping	B
22	Comprehensive AMA Policy Publication Regarding Employed Physicians	G
23	Liberalized Remorse Period for Medicare Advantage Plan Insureds	A
24	AMA Advocacy to Mitigate Medicaid Cuts	B
25	Federal Legislation to Prohibit the Corporate Practice of Medicine	B
26	AMA Ethics Fellowships	Info. Report
27	Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS	B
28	Accountability in the Use of Augmented Intelligence for Prior Authorization	B
29	Educational Materials Regarding Ultra-processed Foods	D
30	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Info. Report
31	Establishing an Advisory Committee on AI/AN Affairs	Info. Report
32	Disability Advisory Group	Info. Report
33	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report
34	Discontinuation of AMA Citation for Distinguished Service	F

13. Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair

01	Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates	Info. Report
02	HOD Representation and Composition	E&B
03	Rights & Privileges of HOD Members	E&B
04	Credentialing of HOD Delegates and Alternate Delegates	E&B
05	Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations	E&B
06	Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD	E&B
07	HOD Delegate and Alternate Delegate Vacancies and Meeting Absences	E&B
08	Business Meetings of the AMA Sections	E&B

09	Continuity of AMA Resident and Fellow Section Governing Council Leadership	E&B

14. Report(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair

01	Guidelines on Chaperones for Sensitive Exams	E&B
02	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	E&B
03	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	E&B
04	Carceral Systems and Practices in Behavioral Health Emergency Care	Info. Report
05	CEJA's Sunset Review of 2016 House Policies	E&B
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	Info. Report

15. Opinion(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair

01	Amendment to Opinion 1.1.1 "Patient-Physician Relationships"	Info. Report
02	Research Involving Pregnant and Lactating Individuals	Info. Report

16. Report(s) of the Council on Medical Education - Kelly Caverzagie, MD, MPH, Chair

01	Council on Medical Education Sunset Review of 2016 House of Delegates' Policies	C
02	Examining ABMS Processes for New Boards	C
03	Support for the Establishment of Indigenous-Led Medical Schools in the United States	C
04	Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States	C

17. Report(s) of the Council on Medical Service - Betty Chu, MD, MBA, Chair

01	Council on Medical Service Sunset Review of 2016 House Policies	G
02	Study of the Federal Employees Health Benefits Program (FEHBP)	Info. Report
03	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts	A
04	Expanding Medicare Coverage of Medical Nutrition Therapy	G
05	Inclusion of Discounted Prescription Medication in Patient Cost-Sharing	A
06	Study of Practice Models for Physicians Performing Procedures Across State Lines	G
07	Private Insurance Coverage of Anti-Obesity Medications	G
08	Rural Health Transformation Program Update & Workforce Challenges	A
09	Nonprofit Status	G

18. Report(s) of the Council on Science and Public Health - Padmini Ranasinghe, MD, MPH, Chair

01	Sunset Review of 2016 House Policies	D
02	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	D
03	Public Health Implications of Food Subsidies	D
04	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	D
05	Removing Artificial Turf in Schools, Parks, and Public Places	D
06	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	D
07	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	E
08	Increased Transparency Among Psychotropic Drug Administration in Prisons	E
09	In Support of a National Drug Checking Registry	E
10	Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation	D

19. Report(s) of the HOD Committee on Compensation of the Officers - Jessica Krant, MD, Chair

01	Report of the House of Delegates Committee on the Compensation of the Officers	F

20. Resolutions

001	Ethical Guidance on Postmortem Sample Collection for Genetic Testing	E&B
002	Physician Workload and Scheduling	E&B
003	Artificial Intelligence to Bolster Physician-Led Team-Based Care	E&B
004	Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities	E&B
005	Impersonation of a Physician	E&B
006	Investigating Moral Injury Related to Organ Procurement Practices	E&B
007	Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software	E&B
008	Senior Physicians Improving Patient Access	E&B
009	Preserving Access to Care for Undocumented Individuals	E&B
010	Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts	E&B
101	Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”	A
102	Study for EMTALA Relief in Psychiatric Facilities	A
103	Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs	A
104	Improving Choice, Competition, and Affordability in the ACA Marketplaces	A
105	Oppose Medicare Advantage Auto Enrollment	A
106	Insurance Coverage for Scalp Cooling (Cold Capping) Therapy	A
107	Oversight of Medicare Advantage Plan	A
108	Ensuring Physician Input in the Development of CMMI Models	A
109	Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy	A
110	Medicaid Coverage for Incarcerated Individuals	A
111	Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia	A

112	Ensuring Coverage and Access to Adult Strabismus Surgery	A
113	Health Insurance Coverage of Hearing Devices and Related Services	A
114	Opposing Alternative Funding Programs	A
115	Patient Continuity Protections During Payer, PBM Changes	A
116	Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs	A
117	Universal Out of Network Benefits	A
118	Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs	A
201	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety	B
202	Using and Defining "Unsupervised Practice of Medicine"	B
203	Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice	B
204	D-400.982 Revision	B
205	Repeal of the Merit-Based Incentive Payment System (MIPS)	B
206	Overall Hospital Quality Star Ratings / CMS Star Ratings	B
207	Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program	B
208	Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness	B
209	Protecting Mental Health Treatment Privacy in Legal Proceedings	B
210	Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation	B
211	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians	B
212	Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding	B
213	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies	B
214	Medical Student Loans Should Not Be Capped	B
215	Oppose Medicare Efficiency Adjustments	B
216	Protecting Healthcare as a Sensitive Location	B
217	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs	B
218	Opposing the Practice of Jury Anchoring in Medical Liability Cases	B
219	Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs	B
220	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians	B
221	Universal Newborn Congenital Cytomegalovirus Screening	B
222	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage	B
223	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations	B
224	Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms	B
225	Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients	B

226	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System	B
227	Standby Capacity Payments and Health IT for Hospitals in Rural Areas	B
228	Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas	B
229	Physicians are not Providers	B
230	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States	B
231	Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges	B
232	Banning Flavored Cannabis E-Cigarettes	B
233	Banning Synthesized, Purified or Derivative Products from Kratom	B
234	Physician Unity in Advocacy Regarding Physician Reimbursement	B
235	Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities	B
236	Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care	B
237	Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan	B
238	Prohibiting the Independent Practice of Medicine by Artificial Intelligence	B
239	Medicare Administrative Contractor Policy Modification	B
240	Ending Private Equity Dividend Recapitalization in Healthcare	B
241	Strengthening Our AMA Efforts Toward CPOM Prohibition	B
242	Reducing Emergency Department Boarding through Payment Reform	B
243	Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions	B
244	Eliminate Administrative Barriers to Appeal Wrongful Denials	B
245	State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA	B
246	Artificial Intelligence Scope of Practice	B
247	Comprehensive ERISA Reform	B
301	Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies	C
302	Excessive Cost of Multi-State DEA Licensure	C
303	Allowing Options for Certification Maintenance	C
304	Increasing the Use of Retired Physicians in Teaching Students and Residents	C
305	Leadership by Physicians for Physicians in Graduate Medical Education (GME)	C
306	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows	C
307	Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine	C
308	Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development	C
309	Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization	C
310	Increasing Capacity and Access to Maternal Health Services in Rural Areas	C

311	Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall	C
312	Advocating for Equitable Application Review in a Single Match System	C
313	Evaluation of Situational Judgement Tests in Medical School Admissions	C
314	Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education	C
315	Expanding the Native Hawaiian Health Scholarship Program Eligibility	C
316	Addressing Transitions Within GME Regarding Orientation Standards	C
317	Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage	C
401	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards	D
402	Strengthening Public Health Protections Against Raw Milk–Associated Illness	D
403	AMA's continued support for COVID-19 vaccination in pregnant individuals and children	D
404	Develop Climate-Conscious Resources for Physicians	D
405	Studying the Environmental Impact of Ambient Clinical Intelligence Use	D
406	Reduce Environmental Impact of Medical Journals	D
407	Colorectal Cancer in Alaskan Native Patients	D
408	Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality	D
409	Eliminate PFAS and Glyphosate in our Food and Environment	D
410	Light Pollution	D
411	Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control	D
412	Guiding Principles of Pandemic Prevention, Preparedness and Response	D
413	Erosion of the Public Evidence Base for Health Policy	D
414	Restoring Balanced Scientific Perspective within the ACIP	D
415	Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions	D
416	Clinical Laboratory Workforce Shortage and Sustainability	D
417	Respiratory Protection for Wildland Firefighters	D
418	Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault	D
419	Examining the Impact of Circadian Disruption from Shift Work During Pregnancy	D
420	Expanding Support for Women Experiencing Homelessness	D
421	Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States	D
422	Expanding Access to High Resolution Anoscopy	D
423	Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)	D
424	Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)	D
425	Prioritizing, Measuring, and Preventing Workplace Violence in Health Care	D
426	Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")	D
427	Infant Feeding Options for HIV-Seropositive Individuals	D
428	Protecting Environmental Health Before, During, and After War	D

429	Adolescent Dating Violence Comprehensive Screening Tool Development	D
430	Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires	D
431	Supporting Transportation Infrastructure Reform for Public Health	D
432	Addressing Public Health Risks of Online Sports Betting	D
433	Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment	D
434	Vaccinations in Physician Offices	D
501	Preregistration in Medical Research	E
502	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care	E
503	Expansion of Psychedelic Assisted Therapy (PAT)	E
504	Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence	E
505	Avoiding misuse of artificial intelligence (AI) in clinical practice	E
506	Access To Gender Affirming Healthcare Including Clinical Trials	E
507	Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications	E
508	Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services	E
509	Preserving Gender-Affirming Surgical Care Access	E
510	Exosome and Peptide Use in Healthcare	E
511	Preserving Specialty Access to Anti-Cancer Agents	E
512	Medical Cannabis Use in Older Adults	E
513	Access, Affordability, and Safety of GLP-1 Receptor Agonists	E
514	Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy	E
515	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure	E
601	Board Chair Term Limits	F
602	Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones	F
603	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy	F
604	Annual Scorecard to Evaluate the AMA’s Impact	F
605	Review of Past Resolutions	F
606	Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	F
607	Shortening the AMA House of Delegates Endorsement Process and Timeline	F
608	Reinstitution of AMA Guides Editorial Panel	F
609	American Medical Association Board Chair Term Limits	F
610	Plant-Based Diets at AMA meetings	F
611	Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices	F
612	Increasing Expert Guidance in AMA Statements	F
613	Preserving Institutional Equity and Inclusivity Efforts	F
614	Inclusive Policy Language for Older Adults	F
615	Condemnation of Attacks on Healthcare Workers and Facilities in Gaza	F

616	Humanitarian and Medical Aid Support to Palestine	F
617	Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association	F
618	Ending AMA Investment in Weapons Manufacturers	F
701	The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models	G
702	Physicians Who Do Not Practice in Hospital Setting	G
703	Parity in Pricing for Anti-Obesity Medications	G
704	Advocating Against Automatic Refill Requests	G
705	Recognizing Physicians as Sexual Assault Forensic Examiners	G
706	Discharge Summaries from Skilled Nursing Facilities	G
707	Malpractice Insurance for Employed Physicians	G
708	Oppose Imposition of Fees on Physicians for Electronic Payment Transfers	G
709	Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine	G
710	Parity in Access to Evidence-Based Obesity Treatment	G
711	Oppose Denials Based on Origin of Referral	G
712	Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions	G
713	Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies	G
714	Physician Case Log Portability	G
715	Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA	G
716	Equal Opportunity for Payment for “On Call” Duty	G
717	Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse	G

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were last modified at the 2024 Interim Meeting by Speakers' Report 02. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- Active member of the AMA.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so they will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.

SEATING ALLOCATION – 2026 ANNUAL MEETING

ADDICTION MEDICINE - 3
American Society of Addiction Medicine (ASAM) – 3
Trustee (Dr. Levin) – 1
Delegates - 2

AMGA - 1
American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11
American Society of Anesthesiologists (ASA) - 9
Former President (Dr. Ehrenfeld) - 1
Delegates – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 21
American College of Cardiology (ACC) - 9
American Society of Echocardiography (ASE) – 2
American Society of Nuclear Cardiology (ASNC) - 2
Heart Rhythm Society (HRS) - 3
Society for Cardiovascular Angiography and Interventions (SCAI) - 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) - 2

CHEST PHYSICIANS - 3
American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 2
Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 16
American Academy of Dermatology Association (AAD) – 7
Trustee (Dr. Van Beek) - 1
Former President (Dr. Resneck) - 1
Delegates - 5
American College of Mohs Surgery (ACMS) - 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Association (ASDSA) - 3
American Society for Laser Medicine and Surgery, Inc. (ASLMS) - 1
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) - 1

EMERGENCY MEDICINE - 15
American Academy of Emergency Medicine (AAEM) - 3
American College of Emergency Physicians (ACEP) - 12
Former President (Dr. Stack) - 1
Delegates - 9
Resident and Fellow Section Delegates - 2

ENDOCRINOLOGY - 4
American Assn of Clinical Endocrinology (AACE) - 2
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 28
American Academy of Family Physicians (AAFP) - 28
Former Board Chair (Dr. Langston) - 1
Delegates - 26
Resident and Fellow Section Delegate – 1

GASTROENTEROLOGY - 10
American College of Gastroenterology (ACG) - 4
American Gastroenterological Association (AGA) - 3
American Society for Gastrointestinal Endoscopy (ASGE) - 3

GERIATRIC MEDICINE - 2
American Geriatrics Society (AGS) – 2

GREAT LAKES - 64
Illinois - 17
Delegates - 13
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 8
Trustee (Dr. Welsh) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Michigan - 16
Delegates - 14
Resident and Fellow Section Delegate - 1
American Osteopathic Association (AOA) – 1
Ohio - 16
Delegates (minus Speaker @ dais) - 11
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Legal Medicine (ACLM) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1
Wisconsin - 7
Delegates - 5
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) - 1

HEART OF AMERICA - 16
Kansas - 6
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Missouri – 10
Former President (Dr. Barbe) - 1
Delegates - 7
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3
Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 2
Infectious Diseases Society of America (IDSA) - 2

INTERNAL MEDICINE - 31
American College of Lifestyle Medicine (ACLsM) - 2
American College of Physicians (ACP) – 27
Trustee (Dr. Fryhofer) - 1
Delegates - 26
Renal Physicians Association (RPA) - 2

MOBILITY CAUCUS - 16
American Acad of Orthopaedic Surgeons (AAOS) – 6
Trustee (Dr. Suk) - 1
Delegates - 5
Former President (Dr. Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1

MOBILITY CAUCUS (cont'd)
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 2
American Society of Interventional Pain Physicians (ASIPP) - 2
International Soc for the Advancement of Spine Surgery (ISASS) -1
North American Spine Society (NASS) - 2

NEUROSCIENCES - 42
Academy of Consultation-Liaison Psychiatry (ACLP) - 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) - 7
Delegates - 4
Resident and Fellow Section Delegates - 3
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 3
Former President (Dr. Carmel) - 1
Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 2
American Epilepsy Society- (AES) - 1
American Psychiatric Association (APA) - 12
Former President (Dr. Harris) - 1
Delegates - 9
Resident and Fellow Section Delegates – 2
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA: Health Professionals Advancing LGBTQ+ Equality – 1
International Pain and Spine Intervention Society (IPSIS) - 2
North American Neuromodulation Society (NANS) - 2
Delegate - 1
Resident and Fellow Section Delegate – 1

NEW ENGLAND - 31
Connecticut - 6
Trustee (Ms. Breig) - 1
Delegates - 4
Medical Student Regional Delegate- 1
Maine - 3
Delegates - 2
Medical Student Regional Delegate- 1
Massachusetts - 17
Delegates - 14
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
New Hampshire - 2
Rhode Island - 2
Vermont – 1

NEW YORK - 35
Former President (Dr. Nielsen) - 1
Delegates - 28
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate – 1
American Society of Neuroradiology (ASN) - 2
American Medical Women's Association (AMWA) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1

NORTH CENTRAL - 20
Iowa - 6
Delegates - 4
Medical Student Regional Delegate - 1
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Resident and Fellow Section Delegate – 1
Nebraska – 4
Delegates - 3
Resident and Fellow Section Delegate – 1
North Dakota - 2
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 21
American Association of Gynecologic Laparoscopists (AAGL) -3
Delegates - 2
Resident and Fellow Section Delegate - 1
American College of Medical Genetics and Genomics (ACMGG) -1
American College of Obstetricians and Gynecologists (ACOG)-15
Delegates - 14
Former President (Dr. Wah)
Resident and Fellow Section Delegate - 1
American Society for Reproductive Medicine (ASRM) - 2

ONCOLOGY - 6
Association for Clinical Oncology (ASCO) – 6
Delegates - 5
Former President (Dr. McAneny)
Resident and Fellow Section Delegate - 1

PACWEST CONFERENCE - 102
Alaska - 1
Arizona - 8
Delegates – 5
American College of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) - 2
California - 56
Trustee (Dr. Huynh) - 1
Delegates - 45
Medical Student Regional Delegates - 3
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
International Society of Hair Restoration Surgery (ISHRS) – 1
North American Neuro-Ophthalmology Society (NANOS)-1
Colorado -10
Former President (Dr. Lazarus) - 1
Delegates - 6
Resident and Fellow Section Delegates - 2
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 3
New Mexico - 2
Oregon - 4
Utah - 4
Delegates - 3
Medical Student Regional Delegate - 1
Washington - 9
Trustee (Dr. Rege) - 1
Delegates - 7
Medical Student Regional Delegate - 1
Wyoming – 1

PALTmed –2
Post-Acute and Long-Term Care Medical Association (PALTmed) – 2

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 7
American Academy of Pediatrics (AAP) - 7
Trustee (Dr. Garretson) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 18
Trustee (Dr. Heine) – 1
Delegates - 15
Medical Student Regional Delegate- 1
American Hernia Society (AHS) - 1

PHYSICAL MEDICINE AND REHABILITATION - 4
American Acad of Physical Med & Rehabilitation (AAPMR) - 3
Association of Academic Physiatrists (AACP) - 1

PREVENTIVE MEDICINE - 7
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 1
American College of Medical Quality (ACMQ) - 1
American College of Occup & Environmental Med (ACOEM) -2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 18
American College of Radiology (ACR) – 9
Delegates – 8
Former President (Dr. Johnson)
Resident and Fellow Section Delegate – 1
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 12
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
LGBTQ+ Section - 1
Medical Student Section (MSS) - 1
Underrepresented in Medicine Advocacy Section (UMAS) - 1
Organized Medical Staff Section (OMSS) - 1
Private Practice Physicians Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 7
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 2
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 122
Alabama - 5
Delegates - 4
Resident and Fellow Section Delegate - 1
Arkansas -5
Trustee (Dr. Ferguson) - 1
Delegates - 3
Medical Student Regional Delegate - 1
Delaware - 2
Former Board Chair (Dr. Permut) – 1
Delegate - 1
District of Columbia - 2
Florida - 23
Former President (Dr. Wilson) - 1
Delegates - 19
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
The Triological Society (TS) - 1
Georgia - 8
Delegates - 7
Medical Student Regional Delegate- 1
Kentucky - 6
Former President (Dr. Hoven) - 1
Delegates - 5
Louisiana - 8
Trustee (Mr. Magrath) - 1
Delegates - 7
Maryland - 8
Delegates - 6
Acad of Physicians in Clinical Research (APCR) - 1
National Medical Association (NMA) - 1
Mississippi - 3
New Jersey - 12
Delegates - 10
Medical Student Regional Delegate- 1
American Assn of Physicians of Indian Origin (AAPIO) - 1
North Carolina - 6
Oklahoma - 6
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Puerto Rico - 2
South Carolina – 7
Former Presidents (Drs. Harmon, Smoak) - 2
Delegates - 4
Medical Student Regional Delegate - 1
Tennessee - 8
Delegates - 6
Medical Student Regional Delegate - 1
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 8
Delegates - 7
Medical Student Regional Delegate- 1
West Virginia – 3
Delegates - 2
Medical Student Regional Delegate- 1

SURGEONS - 60
American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surg (AAFPRS) -1
American Academy of Ophthalmology (AAO) – 5
Delegates - 4
Resident and Fellow Section Delegate – 1
American Acad of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Oto-Head & Neck Surgery (AAOHNS) -4
American Association for Thoracic Surgery (AATS) - 1
American Association of Hip and Knee Surgeons - 2
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 14
Delegates (minus Vice Speaker @ dais) - 13
Resident and Fellow Section Delegate – 1
American Society for Aesthetic Plastic Surgery (ASAPS) -1
American Soc for Metabolic and Bariatric Surgery (ASMBS) -1
American Soc for Reconstructive Microsurgery (ASRMS) -1
American Soc of Cataract and Refractive Surgery (ASCTRS) - 2
American Soc of Colon and Rectal Surgeons (ASCRS) - 2
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) -1
American Soc of Plastic Surgeons (ASPS) - 5
Trustee (Dr. Jeffers) - 1
Delegates - 3
Resident and Fellow Section Delegate – 1
American Soc of Retina Specialists (ASRS) - 2
American Soc of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 3
Delegates - 2
Resident and Fellow Section Delegate – 1
Soc of Amer Gastrointestinal Endo Surgeons (SAGES) -2
The American Soc of Breast Surgeons (ASBS) - 2
The Soc of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 32
Former President (Dr. Bailey) - 1
Former Board Chair (Dr. Kridel) – 1
Delegates - 25
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Allergy, Ashtma & Immunology (ACAAI) - 2

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 6
American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 4
Delegates - 2
Resident and Fellow Section Delegates - 2

OFFICIAL OBSERVERS - 31
Accreditation Association for Ambulatory Health Care
Accreditation Council for Continuing Medical Education (ACCME)
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Federation of State Medical Boards
Federation of State Physician Health Programs
Intealth (ECFMG)
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia
United States Professional Association for Transgender Health
World Medical Association

TELLERS - 4

HOUSE OF DELEGATES · HYATT REGENCY CHICAGO (A-26)

Audience Left — **STAGE** — **Audience Right**

SPEAKER — VICE SPEAKER

	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
1				NEW YORK - 35							SURGEONS - 60						
2										NY/RFS	ACS	ACS	ACS	ACS	ACS	ACS	ACS
3										NY/MSS	ACS/RFS	ACS	ACS	ACS	ACS	ACS	ACS
4									ASN	ASN	SLRS	SLRS	SVS/RFS	SVS	SVS	ASBS	ASBS
5								NIELSEN	AMWA	AMWA/RFS	AATS	ASTS	STS	STS	ASRMS	ASMBS	ASAPS
6				VT -1	MAINE - 3			MASSACHUSETTS			SURGEONS						
7							ME/MSS				AAHKS	AAHKS	JEFFERS	ASPS/RFS	ASPS	ASPS	ASPS
8				MASSACHUSETTS - 17							SURGEONS						
9										MA/RFS	AAOHNS	AAOHNS	AAOHNS	AAOHNS	AAPS	AAFPRS	AACS
10				MASSACHUSETTS							SURGEONS						
11				AAAAI						MA/MSS	AAOA	AAO/RFS	AAO	AAO	AAO	AAO	ASOPRS
12				RHODE ISLAND - 2		NEW HAMPSHIRE - 2		CONNECTICUT - 6			SURGEONS						
13												CT/MSS	BREIG	ASRS	ASRS	ASCTRS	ASCTRS
14				MOBILITY CAUCUS - 16					FAMILY PHYSICIANS - 28								ARS - 1
15	AAOS	AAOS	AAOS/ GURMAN	AAHS	ASSH	ASSH	AOrA	AOFAS									
16									FAMILY PHYSICIANS								
17	AAOS	AAOS	SUK	ASIPP	ASIPP	ISASS	NASS	NASS	LANGSTON								
18				ANESTHESIOLOGY - 11					FAMILY PHYSICIANS								
19	ASA	ASA	ASA	ASA	ASA	EHRENFELD	ASRAPM	ASRAPM	AAFP/RFS								
20				ANESTHESIOLOGY	CARDIOLOGY				FAMILY PHYSICIANS		PEDIATRICS - 7						
21	ASA	ASA	ASA	ACC	ACC	ACC	ACC	ACC			GARRETSON	AAP/RFS					
22				CARDIOLOGY - 21					INTERNAL MEDICINE - 31								
23	ASE	ASE	ASNC	ASNC	ACC	ACC	ACC	ACC	ACLsM	ACLsM							
24				CARDIOLOGY					INTERNAL MEDICINE								
25	HRS	HRS	HRS	SCAI	SCAI	SCMR	SCCT	SCCT									
26				GASTROENTEROLOGY - 10					INTERNAL MEDICINE								
27	AGA	AGA	AGA	ASGE	ASGE	ASGE	ACG	ACG	RPA	RPA							
28				HEMATOLOGY - 2	PENNSYLANIA - 18			GASTROENTEROLOGY	INTERNAL MEDICINE				INFECTIOUS DISEASE - 2		SECTIONS		
29								ACG	ACG	FRYHOFER					MSS	IMG	SPS
30				PENNSYLVANIA					SECTIONS - 12								
31							PA/MSS	HEINE	YPS	RFS	OMSS	UMAS	PPPS	IPPS	WPS	APS	LGBTQ+
32				PENNSYLVANIA			PHYSICAL MEDICINE & REHABILITATION - 4				PREVENTIVE MEDICINE - 7						
33						AHS	AAPMR	AAPMR	AAPRM	AACP	ACOEM	ACOEM	AsMA	AAIM	AAPHP	ACMQ	ACPM
34				OHIO - 16							SERVICES - 7						
35									OH/RFS	OH/RFS	AMSUS	AMSUS	USPHS	AIR FORCE	NAVY	ARMY	VA
36				OHIO			INDIANA - 8				UROLOGY - 6						
37				OH/MSS	ACLM	ACLM/RFS					WELSH	AUA/RFS	AUA/RFS	AUA	AUA	AACU	AACU
38				MICHIGAN - 16			INDIANA		RADIOLOGY		ONCOLOGY - 6						
39									IN/MSS	SIR	SIR	ASCO/RFS	ASCO/ MCANENY				
40				MICHIGAN					RADIOLOGY - 18								
41									MI/RFS	ARRS	ARRS	ARRS	RSNA	RSNA	RSNA	ACR	ACR
42				ILLINOIS - 17					MICHIGAN	RADIOLOGY							
43								IL/MSS	AOA	AAR	ACR/RFS	ACR/ JOHNSON	ACR	ACR	ACR	ACR	ACR
44				ILLINOIS						MISSOURI - 10					KANSAS - 6		
45							IL/RFS	ACNM	SNMMI	MO/MSS					KS/RFS		
46				WISCONSIN - 7				PALTmed - 2		MISSOURI					KANSAS		
47						WI/RFS	UHMS			BARBE	MO/RFS				KS/MSS		

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1					CRITICAL CARE MED - 2		CHEST PHYSICIANS - 3			MT - 1	WY - 1	ID - 1	HAWAII - 2				
2	T	T	T	T													
3	ENDOCRINOLOGY - 4				DERMATOLOGY - 16					CALIFORNIA - 56							
4	AACE	AACE	ES	ES	AAD	AAD	AAD	AAD	AAD	CA/MSS							
5	EMERGENCY MEDICINE - 15						DERMATOLOGY			CALIFORNIA							
6	ACEP	ACEP	ACEP	ACEP	ACEP	ACEP/RFS	VAN BEEK	RESNECK	ASD	CA/MSS							
7	EMERGENCY MEDICINE						DERMATOLOGY			CALIFORNIA							
8	ACEP	ACEP	ACEP	ACEP	ACEP/RFS	STACK	ACMS	ACDS	ASLMS	CA/MSS							
9	EMERGENCY MEDICINE		HOSPITAL MED - 3				DERMATOLOGY			CALIFORNIA							
10	AAEM	AAEM	AAEM				ASDSA	ASDSA	ASDSA	CA/RFS							
11	KENTUCKY - 6						DERMATOLOGY			CALIFORNIA							
12			HOVEN				SID	SPD	CA/RFS								
13	DC - 2		DELAWARE - 2		ADDICTION MED - 3					CALIFORNIA							
14				PERMUT		LEVIN		HUYNH									
15	MARYLAND - 8									CALIFORNIA							
16					APCR	NMA											
17	OKLAHOMA - 6						CALIFORNIA										
18				OK/RFS	OK/MSS		ASRO	ASRO									
19	TENNESSEE - 8									CALIFORNIA							
20				TN/MSS		AVLS											
21	ALABAMA - 5				WEST VIRGINIA - 3					CALIFORNIA			ARIZONA - 8				
22				AL/RFS			WV/MSS			ISHRS	ACNS	NANOS	AIUM	AIUM	ACRO		
23	VIRGINIA - 8									ARIZONA					COLORADO - 10		
24				VA/MSS											CO/RFS		
25	NORTH CAROLINA - 6						NEW MEXICO - 2			WASHINGTON - 9					COLORADO		
26													OMA	LAZARUS	CO/RFS		
27	SOUTH CAROLINA - 7						WASHINGTON								UTAH - 4		
28			HARMON	SC/MSS	SMOAK			REGE	WA/MSS						UT/MSS		
29	FLORIDA - 23						AK - 1	NEVADA - 3				OREGON - 4				GERIATRIC MED - 2	
30																	
31	FLORIDA							SLEEP MEDICINE - 2							OBSTETRICIANS & GYNECOLOGISTS - 21		
32			FL/RFS	WILSON	FL/MSS						ACOG/WAH					ASRM	ASRM
33	FLORIDA							OBSTETRICIANS & GYNECOLOGISTS									
34				TS				ACOG/RFS									ACMGG
35	GEORGIA - 8							OBSTETRICIANS & GYNECOLOGISTS						NEBRASKA - 4			
36				GA/MSS							AAGL/RFS	AAGL	AAGL	NE/RFS			
37	NEW JERSEY - 12							AMGA - 1	THORACIC MED - 2					IOWA - 6			
38				NJ/MSS	AAPIO								OEIS	IA/MSS			
39	MISSISSIPPI - 3			NEW JERSEY				MINNESOTA - 6						SOUTH DAKOTA - 2		NORTH DAKOTA - 2	
40							MN/RFS										
41	LOUISIANA - 8							NEUROSCIENCES - 42									
42		MAGRATH						ASNI	AAPM	AANEM	AANEM	CNS	CNS	AANS	AANS	CARMEL	
43	ARKANSAS - 5				PUERTO RICO - 2			NEUROSCIENCES									
44		FERGUSON	AR/MSS				AES	AAHPM	AAHPM	AANRFS	AAN/RFS	AAN/RFS	AAN	AAN	AAN	AAN	
45	TEXAS - 32							NEUROSCIENCES									
46							TX/RFS	IPSIS	IPSIS	NANS/RFS	NANS	AACAP	AACAP	GLMA	AAAP	ACLP	
47	TEXAS							NEUROSCIENCES									
48							TX/RFS	APA/RFS	APA	APA	APA	APA	APA	APA	AAPL	AAGP	
49	TEXAS							NEUROSCIENCES					PATHOLOGY - 9				
50							TX/MSS	HARRIS	APA/RFS	APA	APA	APA	CAP	CAP	CAP	CAP	
51	TEXAS							TERRITORIES - 2		RHEUMATOLOGY - 2			PATHOLOGY				
52	ACAAI	ACAAI					BAILEY	KRIDEL	GU	VI			ASCP	ASCP	ASCP	ASC	NAME

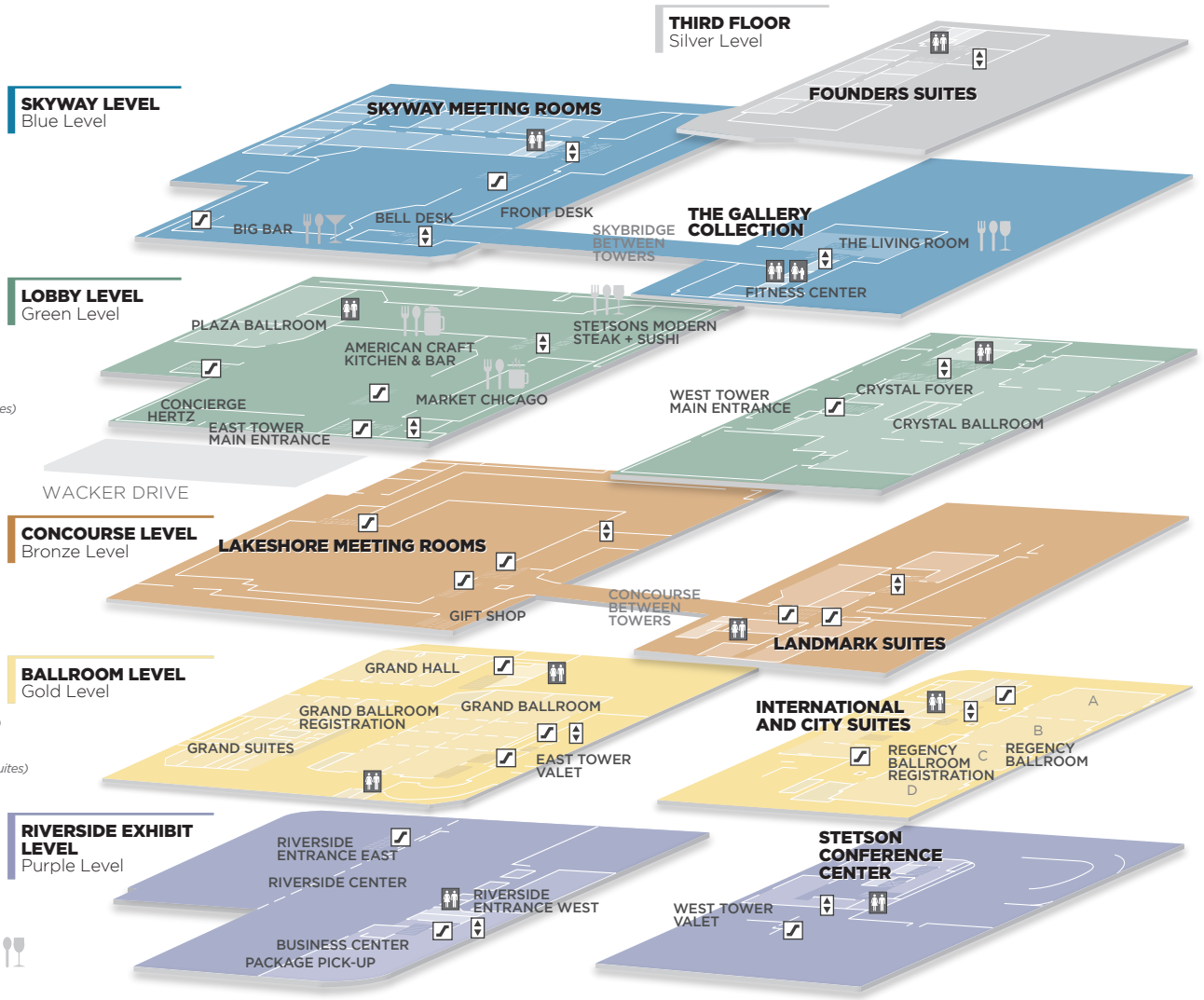
HYATT REGENCY CHICAGO
GUEST MAP

WELCOME TO HYATT REGENCY CHICAGO. Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 52.

- ACAPULCO *(International and City Suites)* — West Tower, Ballroom Level
- ADDAMS *(Founders Suites)* — West Tower, Third Floor
- ADDAMS FOYER — West Tower, Third Floor
- AMERICAN CRAFT KITCHEN & BAR — East Tower, Lobby Level
- ATLANTA *(International and City Suites)* — West Tower, Ballroom Level
- BELL DESK — East Tower, Skyway Level
- BIG BAR — East Tower, Skyway Level
- BURNHAM *(Founders Suites)* — West Tower, Third Floor
- BUSINESS CENTER, PACKAGE ROOM — East Tower, Exhibit Level
- COLUMBIAN *(Landmark Suites)* — West Tower, Concourse Level
- COMISKEY *(Landmark Suites)* — West Tower, Concourse Level
- CONCIERGE — East Tower, Lobby Level
- CRYSTAL BALLROOM — West Tower, Lobby Level
- DUSABLE *(Founders Suites)* — West Tower, Third Floor
- EAST TOWER MAIN ENTRANCE — East Tower, Lobby Level
- EAST TOWER VALET — East Tower, Ballroom Level
- FIELD *(Founders Suites)* — West Tower, Third Floor
- FITNESS CENTER — West Tower, Skyway Level
- FRONT DESK — East Tower, Skyway Level
- THE GALLERY COLLECTION — West Tower, Skyway Level
- GIFT SHOP — East Tower, Concourse Level
- GOLD COAST *(Landmark Suites)* — West Tower, Concourse Level
- GRAND BALLROOM — East Tower, Ballroom Level
- GRAND HALL (ROOMS G-N) — East Tower, Ballroom Level
- GRAND SUITES — East Tower, Ballroom Level
- HAYMARKET *(Landmark Suites)* — West Tower, Concourse Level
- HERTZ — East Tower, Lobby Level
- HONG KONG *(International and City Suites)* — West Tower, Ballroom Level
- HORNER *(Founders Suites)* — West Tower, Third Floor
- THE LIVING ROOM — West Tower, Skyway Level
- MARKET CHICAGO — East Tower, Lobby Level
- McCORMICK *(Founders Suites)* — West Tower, Third Floor
- MICHIGAN *(Lakeshore Meeting Rooms)* — East Tower, Concourse Level
- MONROE *(Lakeshore Meeting Rooms)* — East Tower, Concourse Level
- NEW ORLEANS *(International and City Suites)* — West Tower, Ballroom Level
- OGDEN *(Founders Suites)* — West Tower, Third Floor
- PICASSO *(Landmark Suites)* — West Tower, Concourse Level
- PLAZA BALLROOM — East Tower, Lobby Level
- RANDOLPH *(Lakeshore Meeting Rooms)* — East Tower, Concourse Level
- REGENCY BALLROOM — West Tower, Ballroom Level
- RIVERSIDE CENTER — East Tower, Exhibit Level
- ROOSEVELT *(Lakeshore Meeting Rooms)* — East Tower, Concourse Level
- SAN FRANCISCO *(International and City Suites)* — West Tower, Ballroom Level
- SKYWAY MEETING ROOMS — East Tower, Skyway Level
- SOLDIER FIELD *(Landmark Suites)* — West Tower, Concourse Level
- STETSON CONFERENCE CENTER — West Tower, Exhibit Level
- STETSONS MODERN STEAK + SUSHI — East Tower, Lobby Level
- TORONTO *(International and City Suites)* — West Tower, Ballroom Level
- WATER TOWER *(Landmark Suites)* — West Tower, Concourse Level
- WEST TOWER VALET — West Tower, Exhibit Level
- WRIGHT *(Founders Suites)* — West Tower, Third Floor
- WRIGLEY *(Landmark Suites)* — West Tower, Concourse Level

EAST TOWER

WEST TOWER



SCAN FOR MOBILE MAP

- ELEVATORS
- ESCALATORS AND STAIRS
- RESTROOMS
- MOTHER'S ROOM

ESCALATORS, ELEVATORS AND RESTROOMS are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

CROSSING BETWEEN TOWERS: Cross between towers via the Skybridge or the Concourse. You may also cross from the lobby level via the crosswalk on Stetson Drive.

2026 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2026 Annual Meeting of the House of Delegates in Chicago, Illinois, June 5-10, 2026.

The House of Delegates will convene at 6:00 p.m., on June 5 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Florida 19	Kentucky 5	Montana 1	Ohio 12	Texas 25
Alaska 1	Georgia 7	Louisiana 7	Nebraska 3	Oklahoma 4	Utah 3
Arizona 5	Guam 1	Maine 2	Nevada 3	Oregon 4	Vermont 1
Arkansas 3	Hawaii 2	Maryland 6	New Hampshire 2	Pennsylvania 15	Virgin Islands 1
California 45	Idaho 1	Massachusetts 14	New Jersey 10	Puerto Rico 2	Virginia 7
Colorado 6	Illinois 13	Michigan 14	New Mexico 2	Rhode Island 2	Washington 7
Connecticut 4	Indiana 6	Minnesota 5	New York 28	South Carolina 4	West Virginia 2
Delaware 1	Iowa 4	Mississippi 3	North Carolina 6	South Dakota 2	Wisconsin 5
District of Columbia 2	Kansas 4	Missouri 7	North Dakota 2	Tennessee 6	Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
AMSUS- The Society of Federal Health Professionals 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology Association 5
American Academy of Emergency Medicine 3
American Academy of Family Physicians 26
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 4
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 3
American Academy of Sleep Medicine 2
American Association of Clinical Endocrinology 2
American Association of Clinical Urologists, Inc. 2
American Association of Gynecologic Laparoscopists 2
American Association of Hip and Knee Surgeons* 2
American Association of Neurological Surgeons 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2
American College of Allergy, Asthma and Immunology 2
American College of Cardiology 9
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 9
American College of Gastroenterology 4
American College of Lifestyle Medicine – 2
American College of Obstetricians and Gynecologists 14
American College of Physicians 26
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 14
American Gastroenterological Association 3
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 9
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society for Reproductive Medicine 2
American Society for Surgery of the Hand 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Cataract and Refractive Surgery 2
American Society of Colon and Rectal Surgeons 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Neuroradiology 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 3
American Society of Regional Anesthesia and Pain Medicine 2
American Society of Retina Specialists 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 3
Infectious Diseases Society of America 2
International Pain and Spine Intervention Society 2
North American Spine Society 2
Radiological Society of North America 3
Renal Physicians Association 2
Society for Cardiovascular Angiography and Interventions 2
Society for Vascular Surgery 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Cardiovascular Computed Tomography 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Thoracic Surgeons 2
The American Society of Breast Surgeons 2
The Endocrine Society 2
The Society of Laparoscopic and Robotic Surgeons 2

Remaining eligible national medical specialty societies (58) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, LGBTQ+ Section, Medical Student Section, Underrepresented in Medicine Advocacy Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	351
National Medical Specialty Societies	351
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	26
Resident and Fellow Delegate Representatives	42
Sections	12
Services	5
Total Delegates	**793**

Registration facilities will be maintained at the Hyatt Regency Grand Ballroom Foyer.

Bobby Mukkamala, MD
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

Alex Ding, MD, MS, MBA
Secretary

2025 - 2026

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Bobby Mukkamala..... Flint, Michigan
President-Elect - Willie Underwood, III..... Buffalo, New York
Immediate Past President – Bruce A. Scott..... Louisville, Kentucky
Secretary – Alexander Ding..... Louisville, Kentucky
Speaker, House of Delegates - Lisa Bohman Egbert..... Dayton, Ohio
Vice Speaker, House of Delegates - John H. Armstrong..... Ocala, Florida

David H. Aizuss (2028), *Chair*..... Encino, California
Toluwalase A. Ajayi (2026), *Chair-Elect*..... San Diego, California
Geralyn R. Breig (2028)..... West Port, Connecticut
Scott Ferguson (2026)..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026)..... Atlanta, Georgia
Melissa Garretson (2028)..... Fort Worth, Texas
Marilyn J. Heine (2026)..... Dresher, Pennsylvania
Pauline P. Huynh (2027)..... Oakland, California
Lynne Jeffers (2028)..... Oxnard, California
Ilse R. Levin (2028)..... Silver Spring, Maryland
Justin W. Magrath (2026)..... New Orleans, Louisiana
Sheila D. Rege (2029)..... TriCities, Washington
Michael Suk (2027)..... Danville, Pennsylvania
Marta J. Van Beek (2029)..... Iowa City, Iowa
David Welsh (2028)..... Batesville Indiana

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Jerry P. Abraham, Los Angeles, California, Chair (2029); Mary Ann Contogiannis, Greensboro, North Carolina, Vice Chair, (2029); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2026); Mark N. Bair, Highland, Utah (2027); Lisa Bohman Egbert, Dayton, Ohio, Speaker: Ex Officio (2026); Christopher E. Gribbin, Princeton, New Jersey (2028); Helene Nepomuceno, Las Vegas, Nevada (Resident) (2027); Kevin C. Reilly, Sr., Grovetown, Georgia (2026); Steven C. Thornquist, Bethany, Connecticut (2026); Natasha L. Topolski, Houston, Texas (Student) (2026).
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Rebecca W. Brendel, Brookline, Massachusetts, Chair (2026); Larry E. Reaves, Fort Worth, Texas, Vice Chair (2027); Arthur R. Derse, Shorewood, Wisconsin (2030); Charles J. Hickey, Mechanicsburg, Ohio (2031); Michael G. Knight, Washington, District of Columbia (2029); Kelsey C. Mumford, Pflugerville, Texas, (Resident) (2027); Michael J. Redinger, Vicksburg, Michigan (2032); Ishaan Rischie, Alpharetta, Georgia (Student) (2027); Daniel P. Sulmasy, Washington, District of Columbia (2028).
Secretary: Amber Comer, Chicago, Illinois.

COUNCIL ON LEGISLATION
Tripti C. Kataria, Chicago, Illinois, Chair (2026); Vijaya L. Appareddy, Chattanooga, Tennessee, Vice Chair (2026); Jacob M. Altholz, Denver, Colorado (Resident) (2026); Maryanne C. Bombaugh, Falmouth, Massachusetts (2026); Claude D. Brunson, Ridgeland, Mississippi (2026); Michael D. Chafty, Kalamazoo, Michigan (2026); Hilary E. Fairbrother, Houston, TX (2026); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2026); Ross F. Goldberg, Miami, Florida (2026); Loralie Ma, Fulton, Maryland (2026); Katherine M. Yu, Iowa City, Iowa (Student) (2026); Ann Rosemarie Stroink, Heyworth, Illinois (2026); J. Elizabeth Struble, North Manchester, Indiana (2026).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Jan M. Kief, Merritt Island, Florida, Chair (2027); G. Sealy Massingill, Fort Worth, Texas, Vice Chair (2027); Michelle A. Berger, Austin, Texas (2026); Erin K. Harnish, Longview, Washington (2028); Moudi K. Hubeishy, Chicago, Illinois (Resident) (2026); Gary R. Katz, Dublin, OH (2027); Samuel Lin, Issaquah, Washington (2029); Bhushan H. Pandya, Danville, Virginia (2029); Shilpen A. Patel, San Francisco, California (2028); Lauren E. St. Peter, Kansas City, Missouri (Student) (2026).
Secretary: Adrianne Dues, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Kelly J. Caverzagie, Omaha, Nebraska, Chair (2027); Shannon M. Kilgore, Los Altos, California Chair-Elect (2027); Sherri S. Baker, Edmond, Oklahoma (2029); Ricardo R. Correa Marquez, Phoenix, Arizona (2027); Louito C. Edje, Cincinnati, Ohio (2029); Suja M. Mathew, Hinsdale, Illinois (2026); Rianna K. McNamee, Paramus, New Jersey (2026); Scott H. Pasichow, Maplewood, New Jersey (2029); David J. Savage, La Jolla, California (2029); Seema Sidhu, Morgan Hill California (2028); Joseph T. Whelihan, Philadelphia, Pennsylvania (Resident) (2027); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Betty S. Chu, Birmingham, Michigan, Chair (2026); A. Patrice Burgess, Boise, Idaho, Chair-Elect (2027); Alain A. Chaoui, Boxford, Massachusetts (2029); Steven L. Chen, San Diego, California (2028); Alice Coombs, Richmond, Virginia (2027); Erick A. Eiting, New York, New York (2028); Stephen K. Epstein, Needham, Massachusetts (2026); Ryan P. Englander, New Britain, Connecticut (Student) (2026); Laura Faye Gephart, Temple, Texas (2029); Ravi Goel, Cherry Hill, New Jersey (2026); Hari S. Iyer Detroit, Michigan (Resident) (2027); Ezequiel Silva, III, San Antonio, Texas (2028).
Secretary: Linda Walsh, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Padmini D. Ranasinghe, Baltimore, Maryland, Chair (2026); Tamaan K. Osbourne-Roberts, Denver, Colorado, Chair-Elect (2027); Kavita Shah Arora, Philadelphia, Pennsylvania (2029); Ankush K. Bansal, Westlake, Florida (2027); Joanna Bisgrove, Evanston, Illinois (2026); Donald S. Bourne, Pittsburgh, Pennsylvania (Student) (2026); Jennifer J. Bryan, Brandon, Mississippi (2029); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Rachel Ekaireb, Sacramento, California (Resident) (2026); Marc Mendelsohn, St. Louis, MO (2027); Raymond K. Tu, Washington, DC (2028).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
John W. Poole, Ridgewood, New Jersey (Chair); Jordan M. Warchol, Omaha, Nebraska (Secretary); Hans C. Arora, Chapel Hill, North Carolina; Michael H. Brisman, Old Westbury, New York; Seemal R. Desai, Dallas, Texas; Victoria Gordon, Houston, Texas (Resident); Mary G. Lawrence, Minneapolis, Minnesota; George “Trey” R. Lee, Nashville, Tennessee; Likhit Agrawal, Flower Mound, Texas (Student); Ryan J. Ribeira, Los Gatos, California; Theresa M. Rohr-Kirchgraber, Athens, Georgia; Janice E. Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Rob Jordan, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	Gerald E. Harmon	2021-2022	Nancy H. Nielsen	2008-2009
David O. Barbe	2017-2018	Patrice A. Harris	2019-2020	Jack Resneck, Jr	2022-2023
Lonnie R. Bristow	1995-1996	J. Edward Hill	2005-2006	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Ardis D. Hoven	2013-2014	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Daniel H. Johnson, Jr.	1996-1997	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Jeremy A. Lazarus	2012-2013	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Barbara L. McAneny	2018-2019	Cecil B. Wilson	2010-2011
Jesse Ehrenfeld	2023-2024	Alan R. Nelson	1989-1990	Percy Wootton	1997-1998
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019
Susan Hershberg Adelman	1998-2002	Alan C. Hartford	1989-1990	Harris Pastides	2020-2024
Kendall S. Allred	2008-2009	Drayton Charles Harvey	2020-2023	Rebecca J. Patchin	1988-1989
Raj S. Ambay	2009-2011	William A. Hazel, Jr	2004-2009	Rebecca J. Patchin	2003-2011
Joseph P. Annis	2006-2014	Cyril M. Hetsko	2003-2011	Stephen R. Permut	2010-2018
Grayson W. Armstrong	2019-2021	J. Edward Hill	1996-2004	Pamela Petersen-Crair	1996-1998
John H. Armstrong	2002-2006	Ardis D. Hoven	2005-2012	Dina Marie Pitta	2015-2016
Maya A. Babu	2013-2017	William E. Jacott	1989-1998	Stephen Pool	1995-1996
Susan R. Bailey	2011-2018	Hillary D. Johnson	2001-2002	Liana Puscas	1999-2001
Timothy E. Baldwin	1987-1989	Matthew D. Kagan	1999-2000	Kevin C. Reilly	2003-2005
David O. Barbe	2009-2016	Christopher K. Kay	2008-2012	Ryan J. Ribeira	2013-2014
Regina M. Benjamin	1995-1998	William E. Kobler	2012-2020	J. James Rohack	2001-2008
Scott L. Bernstein	1991-1992	Russell W.H. Kridel	2014-2022	David A. Rosman	2002-2004
Stefano M. Bertozzi	1986-1988	Pratistha Koirala	2021-2025	Samantha L. Rosman	2005-2009
David J. Brailer	1985-1986	Edward L. Langston	2003-2011	Raymond Scalettar	1985-1994
Lonnie R. Bristow	1985-1994	Matthew C. Lawyer	2004-2005	Bruce A. Scott	1998-2002
Madelyn E. Butler	2021-2025	Jeremy A. Lazarus	2005-2011	Aliya Siddiqui	2024-2025
Peter Carmel	2002-2010	W. J. Lewis	1979-1984	Carl A. Sirio	2010-2018
Alice A. Chenault	1984-1985	Audrey J. Ludwig	1990-1991	Sarah Mae Smith	2019-2020
Yank D. Coble	1994-2001	Thomas J. Madejski	2020-2024	Randolph D. Smoak, Jr.	1992-1999
David S. Cockrum	1993-1994	Justin B. Mahida	2009-2010	Steven J. Stack	2006-2014
MaryAnn Contogiannis	1989-1993	Omar Z. Maniya	2016-2017	Michael Suk	1994-1995
Malini Daniel	2012-2013	Barbara L. McAneny	2010-2017	Andrew M. Thomas	1997-1999
Christopher M. DeRienzo	2006-2008	William A. McDade	2016-2020	Jeffrey A. Towson	1998-1999
Nancy W. Dickey	1989-1997	Mary Anne McCaffree	2008-2016	Georgia A. Tuttle	2011-2019
Alexander Ding	2011-2013	Joe T. McDonald	2005-2006	Jordan M. VanLare	2011-2012
William A. Dolan	2007-2011	Samuel J. Mackenzie	2014-2015	Robert M. Wah	2005-2013
Jesse Ehrenfeld	2014-2022	Sandeep “Sunny” Mistry	2000-2001	Peter Y. Watson	2001-2003
Willarda Edwards	2016-2024	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES
2026 Annual Meeting of the AMA House of Delegates

(The following are representatives of the following societies which are represented in the SSS but are not members of the House of Delegates.)

American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Johnny Wu, MD
American College of Medical Toxicology	Jacob Altholz, MD
American Dermatological Association	Murad Alam, MD
American Epilepsy Society	David M. Labiner, MD
American Foregut Society	Jonathan Levy, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Society of Neuroimaging	Ryan Hakimi, MD
American Society of Pain and Neuroscience	Hemant Kalia, MD
American Urogynecologic Society	Jennifer Wu, MD
AO North America	Augustine Saiz, MD
Association of Physicians of Pakistani Descent of North America	Raffia Qutab, MD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Mark Melhorn, MD
Korean American Medical Association	Jennifer Inhae Lee, MD
Orthopaedic Trauma Association	Milan K. Sen, MD
Skin of Color Society	Elizabeth Kiracofe, MD
Society for Maternal-Fetal Medicine	Andrea L. Greiner, MD
The OrthoForum	William Ritchie, MD
Urgent Care College of Physicians	Lindsey Fish, MD

MEMBERS OF THE HOUSE OF DELEGATES - JUNE 2026
The following is a list of credentialed delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama
Delegates
B Jerry Harrison, MD, Haleyville, AL
John Meigs Jr., MD, Brent, AL
William Schneider, MD, Huntsville, AL
George C. Smith Jr., MD, Lineville, AL
Alternate Delegates
Alexis Mason, MD, Tuscaloosa, AL
Charles Jeremy Thompson, MD, Sheffield, AL
Jane Weida, MD, Tuscaloosa, AL
Tom Weida, MD, Tuscaloosa, AL

Alaska State Medical Association
Delegate
Alex Malter, MD, MPH, Juneau, AK
Alternate Delegate
Rhene Merkouris, MD, Anchorage, AK

Arizona Medical Association
Delegates
David Baltazer, DO, Scottsdale, AZ
Veronica K. Dowling, MD, Lakeside, AZ
Gary R. Figge, MD, Tucson, AZ
M Zuhdi Jasser, MD, Phoenix, AZ
Marc Leib, MD, Phoenix, AZ
Alternate Delegates
Ilana Addis, MD, Tucson, AZ
Nadeem Kazi, MD, Casa Grande, AZ
James Nachbar, MD, Scottsdale, AZ
Marla Rejbi, DO, Phoenix, AZ

Arkansas Medical Society
Delegates
Omar Atiq, MD, Little Rock, AR
Stephen Magie, MD, Conway, AR
Danny Wilkerson, MD, Little Rock, AR
Alternate Delegates
Alan Wilson, MD, Monticello, AR

California Medical Association
Delegates
Jerry P. Abraham, MD, MPH, CMQ, Los Angeles, CA
Barbara J. Arnold, MD, Sacramento, CA
Patricia L. Austin, MD, Alamo, CA
Dirk Stephen Baumann, MD, Burlingame, CA
Peter N. Bretan, Jr., MD, Novato, CA
Resa Caivano, MD, Inglewood, CA
J Brennan Cassidy, MD, Newport Beach, CA
Jack Chou, MD, Baldwin Park, CA
Jason Cord, MD, Anaheim, CA
Maisha Draves, MD, Fairfield, CA
Suparna Dutta, MD, Oakland, CA
Kyle P. Edmonds, MD, San Diego, CA
Sergio Flores, MD, San Diego, CA
George Fouras, MD, Los Angeles, CA
Dev A. GnanaDev, MD, Upland, CA
Brian Grady, MD, San Francisco, CA
Donaldo Hernandez, MD, Santa Cruz, CA
Robert Hertzka, MD, Rancho Santa Fe, CA
Jennifer Hone, MD, Santa Barbara, CA
Samuel Huang, MD, Los Angeles, CA
Jeff Klingman, MD, Orinda, CA
Mehzabin Lala, Pamona, CA
John Lam, MD, Woodland Hills, CA
Man Kit Leung, MD, San Francisco, CA
Terence Lin, MD, Palo Alto, CA
John Maa, MD, San Francisco, CA
Ramin Manshadi, MD, Stockton, CA
Theodore Mazer, MD, Fort Myers, FL
Kelly McCue, MD, Davis, CA
Alex McDonald, MD, Woodland Hills, CA
Mihir Parikh, MD, La Jolla, CA
Stephen Parodi, MD, Oakland, CA
Eric Rafla-Yuan, MD, San Diego, CA
Albert Ray, MD, San Diego, CA
Ryan J. Ribeira, MD, Mountain View, CA
Katrina Saba, MD, Oakland, CA
Shireen Saxena, MD, Los Angeles, CA
Ilan Shapiro Strygler, MD, Commerce, CA
Diana Shiba, MD, Pasadena, CA
Seema Sidhu, MD, Fremont, CA
Tatiana W. Spirtos, MD, Redwood City, CA
James J. Strebig, MD, Irvine, CA
Shannon Udovic-Constant, MD, San Francisco, CA
Holly Yang, MD, San Diego, CA
Anna Yap, MD, Carmichael, CA
Alternate Delegates
Ameena Ahmed, Oakland, CA
Mary Alice Ambrose, MD, Santa Clara, CA
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Robert Summerer, DO, Madison, SD

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Yasser Zeid, MD, Longview, TX

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Yushra Rashid, Bryan, TX
Mammen Sam, MD, Pearland, TX
Linda Siy, MD, Fort Worth, TX
Rajeev Suri, MD, Shavano Park, TX
Andrew Widmer, MD, Celina, TX

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Anne Lin, MD, Salt Lake Cty, UT

Alternate Delegates

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Vermont Medical Society

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Vivienne Meljen, MD, Vancouver, WA
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West Virginia State Medical Association

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Joseph Barry Selby, MD, Morgantown, WV

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Bonhomme Joseph "Joe" Prud'homme, MD, Morgantown, WV

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Tosha Wetterneck, MD, Madison, WI
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Jade Anderson, MD, Norwalk, CT
Nandini M. Meyersohn, MD, Cambridge, MA
Kevin C. Reilly Sr., MD, Elizabethtown, KY
Alternate Delegate
Laura E. Traube, MD, San Luis Obispo, CA

Renal Physicians Association
Delegates
Rebecca Schmidt, DO, Morgantown, WV
Kareen Simpson, MD, Chicago, IL
Alternate Delegate
Abigail Bradner, MD, Nashville, TX

Society for Cardiovascular Angiography and Interventions
Delegates
J. Jeffrey Marshall, MD, Atlanta, GA
Edward Tuohy IV, MD, Milford, CT

Society for Cardiovascular Magnetic Resonance
Delegate
Anthon Fuisz, MD, New York, NY

Society for Investigative Dermatology
Delegate
Erica Dommasch, MD, Boston, MA
Alternate Delegate
Daniel Bennett, MD, Boston, MA

Society for Pediatric Dermatology
Delegate
Dawn Davis, MD, Rochester, MN
Alternate Delegate
Marilyn Liang, MD, Boston, MA

Society for Vascular Surgery
Delegates
Kaitlyn Dobesh, MD, Detroit, MI
Nicolas J. Mouawad, MD, Bay City, MI

Society of American Gastrointestinal Endoscopic Surgeons
Delegates
Kellie Marie McFarlin, MD, Detroit, MI

Kevin Reavis, MD, Portland, OR
Alternate Delegate
Jarvis Walters, DO, Peoria, AZ

Society of Cardiovascular Computed Tomography
Delegates
Kanae Mukai, MD, Salinas, CA
Irfan Zeb, MD, Morgantown, WV

Society of Critical Care Medicine
Delegates
Kathleen Doo, MD, Orinda, CA
Devang Sanghavi, MD, Jacksonville, FL
Alternate Delegates
Tina R. Shah, MD, Westfield, NJ
Daniel Udrea, MD, Loma Linda, CA

Society of Hospital Medicine
Delegates
Steven Deitelzweig, MD, New Orleans, LA
Brad Flansbaum, DO, New York, NY
Ron Greeno, MD, Los Angeles, CA

Society of Interventional Radiology
Delegates
Meridith Englander, MD, FSIR, Albany, NY
Natosha Monfore, DO, Oklahoma City, OK

Society of Nuclear Medicine and Molecular Imaging
Delegate
Gary L. Dillehay, MD, Chicago, IL
Alternate Delegate
Benjamin Franc, MD, Menlo Park, CA

Society of Thoracic Surgeons
Delegates
Jeffrey P. Gold, MD, Omaha, NE
David D. Odell, MD, Ann Arbor, MI

The American Society of Breast Surgeons
Delegates
David Rubin Brenin, MD, Charlottesville, VA
Steven Chen, MD, MBA, San Diego, CA

The Society of Laparoscopic and Robotic Surgeons
Delegates
Camran Nezhat, MD, Redwood City, CA
Ceana Nezhat, MD, Atlanta, GA
Alternate Delegate
Sharona Ross, MD, Tampa, FL

Triological Society, The
Delegate
Michael E. Hoffer, MD, Miami, FL
Alternate Delegate
Andrew Murr, MD, San Francisco, CA

Undersea and Hyperbaric Medical Society
Delegate
Laurie Gesell, MD, Brookfield, WI
Alternate Delegate
Helen Gelly, MD, Marietta, GA

Veterans Affairs
Delegate
Victoria Sharp, MD, Iowa City, IA
Alternate Delegate
Haipeng Zhang, DO, Boston, MA

Academic Physicians Section
Delegate
Mark Meyer, MD, Kansas City, KS
Alternate Delegate
Kamalika Roy, MD, Portland, OR

Integrated Physician Practice Section
Delegate
Luis Garcia, MD, Chicago, IL
Alternate Delegate
Steven Wang, MD, Bakersfield, CA

International Medical Graduates Section
Delegate
Deepu Sudhakaran, MD, Chesterfield, MO
Alternate Delegate
Roopa Naik, MD, S Abingtn Twp, PA

LGBTQ+ Section
Delegate
Hailey Greenstone, Cambridge, MA
Alternate Delegate
Janet Jacobson, MD, Anaheim, CA

Medical Student Section
Delegate
Jared Buteau, Greenville, SC
Alternate Delegate
Sneha Kapil, St. Augustine, FL

Organized Medical Staff Section
Delegate
Nancy Fan, MD, Wilmington, DE
Alternate Delegate
Nita Shumaker, MD, Hixson, TN

Private Practice Physician Section
Delegate
Timothy G. Mc Avoy, MD, Waukesha, WI
Alternate Delegate
Kieran McAvoy, MD, Brookfield, WI

Resident and Fellow Section
Delegate
Nikita Sood, MD, Providence, RI
Alternate Delegate
Sarah Mae Smith, MD, PhD, Irvine, CA

Senior Physicians Section
Delegate
Douglas M. DeLong, MD, Cherry Valley, NY
Alternate Delegate
Edward T. Bope, MD, Naples, FL

Underrepresented in Medicine Advocacy Section
Delegate
Luis Seija, MD, Boston, MA
Alternate Delegate
Josephine Fowler, MD, Marlborough, MA

Women Physicians Section
Delegate
Shazia Pathan, MD, Las Vegas, NV
Alternate Delegate
Rachel Solnick, MD, New York, NY

Young Physicians Section
Delegate
Sean Figy, MD, Omaha, NE
Alternate Delegate
Christopher Libby, MD, Anaheim, CA

Sectional Resident and Fellows with Endorsing Society

Delegates

Maria Kerrigan Haupt, MD, MS, Bryan, TX (Endorsed by American Academy of Family Physicians)
Oluwasegun Paul Emenogu, MD, Chicago, IL (Endorsed by American Academy of Neurology)
Laila Koduri, MD, MPH, Washington, DC (Endorsed by American Academy of Neurology)
Daniel Lee, MD, Mobile, AL (Endorsed by American Academy of Neurology)
Aaisha Gulani, MD, Memphis, TN (Endorsed by American Academy of Ophthalmology)
Joey Whelihan, MD, Philadelphia, PA (Endorsed by American Academy of Pediatrics)
Reilly Bealer, MD, Chapel Hill, NC (Endorsed by American Association of Gynecologic Laparoscopists)
Anna Heffron, MD, PhD, New York, NY (Endorsed by American College of Emergency Physicians)
Leanna "Leif" Knight, MD, Providence, RI (Endorsed by American College of Emergency Physicians)
Rijul Asri, MD, Princeton, NJ (Endorsed by American College of Legal Medicine)
Laurie Lapp, MD, MPH, Columbia, SC (Endorsed by American College of Obstetricians and Gynecologists)
Anirudh Gautam, MD, Burlington, MA (Endorsed by American College of Radiology)
Michael Visenio, MD, MPH, Omaha, NE (Endorsed by American College of Surgeons)
Medha Reddy, MD, Chicago, IL (Endorsed by American Medical Women's Association)
Danielle Rivera, MD, Albuquerque, NM (Endorsed by American Psychiatric Association)
Karthik V. Sarma, MD, PhD, Beaverton, OR (Endorsed by American Psychiatric Association)
Samantha Lund, MD, Springfield, IL (Endorsed by American Society of Plastic Surgeons)
Haritha Pavuluri, MD, New Orleans, LA (Endorsed by American Urological Association)
Dhruv Puri, MD, San Diego, CA (Endorsed by American Urological Association)
Dayna Isaacs, MD, MPH, Sacramento, CA (Endorsed by Association for Clinical Oncology)
Abhishek Dharan, MD, Redlands, CA (Endorsed by California Medical Association)
Samantha Pavlock, MD, PhD, Fresno, CA (Endorsed by California Medical Association)
Jacob Altholz, MD, Denver, CO (Endorsed by Colorado Medical Society)
Lavanya Easwaran, MD, MPH, Denver, CO (Endorsed by Colorado Medical Society)
Kayla Tran, MD, MPH, Tampa, FL (Endorsed by Credentialed for A62 Florida Medical Association)
Jacob Cabrejas, MD, Chicago, IL (Endorsed by Illinois State Medical Society)
Ashley Glass, DO, MA, Kansas City, KS (Endorsed by Kansas Medical Society)
Elizabeth Conner, MD, MPH, Boston, MA (Endorsed by Massachusetts Medical Society)
Rajadhar Reddy, MD, MSc, Fairhope, AL (Endorsed by Medical Association of the State of Alabama)
Kylee Borger, MD, MPH, New York, NY (Endorsed by Medical Society of the State of New York)
Hari S. Iyer, MD, Detroit, MI (Endorsed by Michigan State Medical Society)
Michael Rigby, MD, PhD, Rochester, MN (Endorsed by Minnesota Medical Association)
Jay Devineni, MD, MPH, MSJ, Saint Louis, MO (Endorsed by Missouri State Medical Association)
Mollie Dreicer, MD, Omaha, NE (Endorsed by Nebraska Medical Association)
James Mossner, MD, MS, Chicago, IL (Endorsed by North American Neuromodulation Society)
Megan Chiu, MD, Cleveland, OH (Endorsed by Ohio State Medical Association)
Brady Iba, DO, Edmond, OK (Endorsed by Oklahoma State Medical Association)
Shaminy Manoranjithan, MD, Grand Rapids, MI (Endorsed by Society for Vascular Surgery)
Victoria Gordon, DO, Houston, TX (Endorsed by Texas Medical Association)
Christopher Wong, MD, MSc, Houston, TX (Endorsed by Texas Medical Association)
Abby Willgruber, MD, Madison, WI (Endorsed by Wisconsin Medical Society)

Alternate Delegates

Ethan Stephens, DO, MS, Houston, TX (Endorsed by Aerospace Medical Association)
Robert Dunn, MD, Baltimore, MD (Endorsed by American Academy of Emergency Medicine)
Katy Wyszynski, DO, MS, Fort Worth, TX (Endorsed by American Academy of Emergency Medicine)
Ida Vaziri, MD, Washington, DC (Endorsed by American Academy of Neurology)
Tristan Mackey, MD, Peoria, IL (Endorsed by American Academy of Pediatrics)
Mona Amin, MD, Washington, DC (Endorsed by American Academy of Physical Medicine and Rehabilitation)
Rebecca Peoples, MD, New York, NY (Endorsed by American Association of Public Health Physicians)
Allison Young, MD, Chicago, IL (Endorsed by American College of Emergency Physicians)
Bianca Radut, DO, Shreveport, LA (Endorsed by American College of Nuclear Medicine)
Allie Conry, MD, Memphis, TN (Endorsed by American College of Obstetrician Gynecologists)
Katie Claycomb, MD, Washington, DC (Endorsed by American College of Obstetricians and Gynecologists)
Rachel Ekaireb, MD, Sacramento, CA (Endorsed by American College of Surgeons)
Helene Nepomuceno, MD, Union City, CA (Endorsed by California Medical Association)
Daniel Kerekes, MD, MHS, New Hyde Park, NY (Endorsed by Connecticut State Medical Society)
Jean-Luc Germany, MD, Chicago, IL (Endorsed by Illinois State Medical Society)
Andrew Ray, MD, MBA, MSc, Louisville, KY (Endorsed by Kentucky Medical Association)
Pooja Patel, MD, Boston, MA (Endorsed by Massachusetts Medical Society)
Katherine Russell, DO, MSPH, Atlanta, GA (Endorsed by Medical Association of Georgia)
Sheryl Fuehrer, MD, Rochester, MN (Endorsed by Minnesota Medical Association)
Katherine Holder, MD, Rochester, MN (Endorsed by Minnesota Medical Association)
Varnica Bajaj, MD, Omaha, NE (Endorsed by Nebraska Medical Association)
Samantha M. Thomas, MD, Cleveland, OH (Endorsed by Ohio State Medical Association)

Dalton Delaney, DO, PhD, MHA, Oklahoma City, OK (Endorsed by Oklahoma State Medical Association)
Ashton Glover Gatewood, DO, MPH, Bixby, OK (Endorsed by Oklahoma State Medical Association)
Holley See, DO, Tulsa, OK (Endorsed by Oklahoma State Medical Association)
Amanda Kahn, MD, Pennsylvania, PA (Endorsed by Pennsylvania Medical Society)
Nidhi K. Reddy, MD, Chicago, IL (Endorsed by Society for Vascular Surgery)

Regional Medical Students with Endorsing Society

Delegates

Elizabeth Dawson, Little Rock, AR (Endorsed by Arkansas Medical Society)
Preston Dang, Mission Viejo, CA (Endorsed by California Medical Association)
Isabel Nguyen, Pomona, CA (Endorsed by California Medical Association)
Phanisri Tummala, San Jose, CA (Endorsed by California Medical Association)
Karina Patel, Irvine, CA (Endorsed by Connecticut State Medical Society)
Ami Dave, Suwanee, GA (Endorsed by Florida Medical Association)
Sami Muslmani, Chicago, IL (Endorsed by Illinois State Medical Society)
Layla Ahmadi, Haute, IN (Endorsed by Indiana State Medical Association)
Katherine M. Yu, Iowa City, IA (Endorsed by Iowa Medical Society)
Ella Wright, Overland Park, KS (Endorsed by Kansas Medical Society)
Varun Kota, Saco, ME (Endorsed by Maine Medical Association)
Isabel Ball, Somerville, MA (Endorsed by Massachusetts Medical Society)
Kyle Smith, Port Orange, FL (Endorsed by Medical Association of Georgia)
Chelsea Chen, Short Hills, NJ (Endorsed by Medical Society of New Jersey)
Akhil Mahant, Rochester, NY (Endorsed by Medical Society of the State of New York)
Yumna Rahman, Richmond, VA (Endorsed by Medical Society of Virginia)
Mason Tuttle, Kansas City, MO (Endorsed by Missouri State Medical Association)
Jessy Silfer, Cleveland, OH (Endorsed by Ohio State Medical Association)
Lily Robistow, Owasso, OK (Endorsed by Oklahoma State Medical Association)
Denise Ocampo, Hummelstown, PA (Endorsed by Pennsylvania Medical Society)
Kayla Jernigan, Greenville, SC (Endorsed by South Carolina Medical Association)
Paneeta Mohapatra, Memphis, TN (Endorsed by Tennessee Medical Association)
Mary Conley, Fort Worth, TX (Endorsed by Texas Medical Association)
Laura Hult, Salt Lake Cty, UT (Endorsed by Utah Medical Association)
Patrick Hewes, Spokane, WA (Endorsed by Washington State Medical Association)
Mitchell Nelson, Charleston, WV (Endorsed by West Virginia State Medical Association)

Alternate Delegates

Allison Kelley, Aurora, CO (Endorsed by Colorado Medical Society)
Daniel Brocke, Hartford, CT (Endorsed by Connecticut State Medical Society)
Zhuochen Yuan, Miami, FL (Endorsed by Florida Medical Association)
Isaac Meng, Indianapolis, IN (Endorsed by Indiana State Medical Association)
Sara Armstrong, Overland Park, KS (Endorsed by Kansas Medical Society)
Lillian Cain, Worcester, MA (Endorsed by Massachusetts Medical Society)
Grace Johnson, Boston, MA (Endorsed by Massachusetts Medical Society)
Kareena Dash, Alpharetta, GA (Endorsed by Medical Association of Georgia)
Krisha Darji, Deptford, NJ (Endorsed by Medical Society of New Jersey)
Myra Moghal, New York, NY (Endorsed by Medical Society of the State of New York)
Vignesh Senthilkumar, Charlottesville, VA (Endorsed by Medical Society of Virginia)
Saad Ramsha, Leesburg, VA (Endorsed by Mississippi State Medical Association)
Druv Bhagavan, St Louis, MO (Endorsed by Missouri State Medical Association)
Joel Dumonsau, Omaha, NE (Endorsed by Nebraska Medical Association)
Austin Osborn, Omaha, NE (Endorsed by Nebraska Medical Association)
Micah Char, Las Vegas, NV (Endorsed by Nevada State Medical Association)
Jordon Ma, Chino Hills, CA (Endorsed by Nevada State Medical Association)
Rehet Chugh, Fresno, CA (Endorsed by New Mexico Medical Society)
Shalmali Bhadkamkar, Toledo, OH (Endorsed by Ohio State Medical Association)
Kelly Delano, Crescent Spgs, KY (Endorsed by Ohio State Medical Association)
Sarah Boliek, Corvallis, OR (Endorsed by Oregon Medical Association)
Samyukta Karthik, State College, PA (Endorsed by Pennsylvania Medical Society)
Camryn Briggs, Bluffton, SC (Endorsed by South Dakota State Medical Association)
Nate Tamez, Harrogate, TN (Endorsed by Tennessee Medical Association)
Camille Bourgeois, Houston, TX (Endorsed by Texas Medical Association)
Sanjay Neerukonda, Houston, TX (Endorsed by Texas Medical Association)

Reference Committee Hearing Room Assignments
Saturday, June 6

15 minutes after HOD second session close		**Room**
A	Medical Service	Regency A
B	Legislation	Grand Ballroom
C	Medical Education	Crystal Ballroom B
D	Public Health	Regency D
E	Science and Technology	Regency C
E&B	Ethics & Bylaws	Grand Hall I/J
F	Finance	Grand Hall K/L
G	Medical Practice	Regency B

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2026 Annual Meeting
Notes on Orders of Business

Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 5, 6:00pm

SECOND SESSION, Saturday, June 6, 12:00pm

THIRD SESSION, Monday, June 8, 9:00am

FOURTH SESSION, Tuesday, June 9, 9am (or 15 minutes after elections conclude) - 3:00pm

NOTE: The Inauguration of Willie Underwood III, MD, MSc, MPH, as the 181st President of the American Medical Association, will be held at 5:00pm in the Crystal Ballroom of the Hyatt Regency Chicago.

FIFTH SESSION, Wednesday, June 10, 8:30am – completion of business

Summary of Fiscal Notes (A-26)

Report(s) of the Board of Trustees

01	Annual Report	Minimal
02	New Specialty Organizations Representation in the House of Delegates	Minimal
03	2025 Grants and Donations	
04	AMA 2027 Dues	Minimal
05	Update on Corporate Relationships	
06	AMA Performance, Activities and Status in 2025	
07	Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026	
08	Council on Legislation Sunset Review of 2016 House Policies	Minimal
09	American Medical Association Optimal Health Outcomes Annual Report	
10	AMA Efforts on Medicare Payment Reform	
11	AMA Public Health Strategy Update	
12	The Uniform Health-Care Decisions Act	Minimal
13	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes	Minimal
14	Binding Arbitration in Health Insurance Contracts	Minimal
15	Protecting the Prescriptive Authority of Plenary Licensed Physicians	Minimal
16	Demographic Report of the House of Delegates and AMA Membership	
17	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report	Major
18	Report on the Preservation of Independent Medical Practice	
19	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	Minimal
20	Mitigating the Impact of Excessive Prior Authorization Processes	Minimal
21	Abolishing Venue Shopping	Minimal
22	Comprehensive AMA Policy Publication Regarding Employed Physicians	Minimal
23	Liberalized Remorse Period for Medicare Advantage Plan Insureds	Minimal
24	AMA Advocacy to Mitigate Medicaid Cuts	Minimal
25	Federal Legislation to Prohibit the Corporate Practice of Medicine	Minimal

Summary of Fiscal Notes (A-26)

26	AMA Ethics Fellowships	
27	Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS	Minimal
28	Accountability in the Use of Augmented Intelligence for Prior Authorization	Minimal
29	Educational Materials Regarding Ultra-processed Foods	Minimal
30	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	
31	Establishing an Advisory Committee on AI/AN Affairs	
32	Disability Advisory Group	
33	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	
34	Discontinuation of AMA Citation for Distinguished Service	Minimal

Report(s) of the Council on Constitution and Bylaws

01	Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates	
02	HOD Representation and Composition	
03	Rights & Privileges of HOD Members	
04	Credentialing of HOD Delegates and Alternate Delegates	
05	Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations	
06	Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD	
07	HOD Delegate and Alternate Delegate Vacancies and Meeting Absences	
08	Business Meetings of the AMA Sections	
09	Continuity of AMA Resident and Fellow Section Governing Council Leadership	

Report(s) of the Council on Ethical and Judicial Affairs

01	Guidelines on Chaperones for Sensitive Exams	Minimal
02	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	Minimal
03	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
04	Carceral Systems and Practices in Behavioral Health Emergency Care	

05	CEJA's Sunset Review of 2016 House Policies	Minimal
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	

Opinion(s) of the Council on Ethical and Judicial Affairs

01	Amendment to Opinion 1.1.1 "Patient-Physician Relationships"	
02	Research Involving Pregnant and Lactating Individuals	

Report(s) of the Council on Medical Education

01	Council on Medical Education Sunset Review of 2016 House of Delegates' Policies	Minimal
02	Examining ABMS Processes for New Boards	Minimal
03	Support for the Establishment of Indigenous-Led Medical Schools in the United States	Major - $100,000 Non-staff travel and meeting expenses
04	Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States	Major - $80,000 Non-staff travel and meeting expenses

Report(s) of the Council on Medical Service

01	Council on Medical Service Sunset Review of 2016 House Policies	
02	Study of the Federal Employees Health Benefits Program (FEHBP)	
03	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts	Minimal
04	Expanding Medicare Coverage of Medical Nutrition Therapy	Minimal
05	Inclusion of Discounted Prescription Medication in Patient Cost-Sharing	Minimal
06	Study of Practice Models for Physicians Performing Procedures Across State Lines	Minimal
07	Private Insurance Coverage of Anti-Obesity Medications	Minimal
08	Rural Health Transformation Program Update & Workforce Challenges	Minimal
09	Nonprofit Status	Minimal

Report(s) of the Council on Science and Public Health

01	Sunset Review of 2016 House Policies	
02	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	Modest
03	Public Health Implications of Food Subsidies	Minimal

Summary of Fiscal Notes (A-26)

04	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	Minimal
05	Removing Artificial Turf in Schools, Parks, and Public Places	Minimal
06	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	Minimal
07	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	Minimal
08	Increased Transparency Among Psychotropic Drug Administration in Prisons	Minimal
09	In Support of a National Drug Checking Registry	Minimal
10	Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation	Modest

Report(s) of the HOD Committee on Compensation of the Officers

01	Report of the House of Delegates Committee on the Compensation of the Officers	

Resolutions

001	Ethical Guidance on Postmortem Sample Collection for Genetic Testing	Minimal
002	Physician Workload and Scheduling	Modest
003	Artificial Intelligence to Bolster Physician-Led Team-Based Care	Moderate
004	Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities	Minimal
005	Impersonation of a Physician	Modest
006	Investigating Moral Injury Related to Organ Procurement Practices	Modest
007	Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software	Modest
008	Senior Physicians Improving Patient Access	Modest
009	Preserving Access to Care for Undocumented Individuals	Modest
010	Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts	Minimal
101	Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”	Modest
102	Study for EMTALA Relief in Psychiatric Facilities	Modest

Summary of Fiscal Notes (A-26)

103	Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs	Moderate
104	Improving Choice, Competition, and Affordability in the ACA Marketplaces	Modest
105	Oppose Medicare Advantage Auto Enrollment	Minimal
106	Insurance Coverage for Scalp Cooling (Cold Capping) Therapy	Minimal
107	Oversight of Medicare Advantage Plan	Moderate
108	Ensuring Physician Input in the Development of CMMI Models	Minimal
109	Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy	Modest
110	Medicaid Coverage for Incarcerated Individuals	Modest
111	Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia	Moderate
112	Ensuring Coverage and Access to Adult Strabismus Surgery	Modest
113	Health Insurance Coverage of Hearing Devices and Related Services	Minimal
114	Opposing Alternative Funding Programs	Modest
115	Patient Continuity Protections During Payer, PBM Changes	Moderate
116	Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs	Modest
117	Universal Out of Network Benefits	Modest
118	Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs	Moderate
201	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety	Minimal
202	Using and Defining “Unsupervised Practice of Medicine”	Moderate
203	Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice	Modest
204	D-400.982 Revision	Moderate
205	Repeal of the Merit-Based Incentive Payment System (MIPS)	Moderate
206	Overall Hospital Quality Star Ratings / CMS Star Ratings	Modest
207	Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program	Minimal

208	Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness	Modest
209	Protecting Mental Health Treatment Privacy in Legal Proceedings	Modest
210	Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation	Modest
211	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians	Modest
212	Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding	Moderate
213	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies	Modest
214	Medical Student Loans Should Not Be Capped	Minimal
215	Oppose Medicare Efficiency Adjustments	Modest
216	Protecting Healthcare as a Sensitive Location	Moderate
217	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs	Moderate
218	Opposing the Practice of Jury Anchoring in Medical Liability Cases	Minimal
219	Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs	Modest
220	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians	Moderate
221	Universal Newborn Congenital Cytomegalovirus Screening	Modest
222	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage	Moderate
223	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations	Moderate
224	Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms	Modest
225	Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients	Minimal
226	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System	Moderate
227	Standby Capacity Payments and Health IT for Hospitals in Rural Areas	Moderate
228	Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas	Moderate

Summary of Fiscal Notes (A-26)

229	Physicians are not Providers	Moderate
230	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States	Moderate
231	Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges	Modest
232	Banning Flavored Cannabis E-Cigarettes	Modest
233	Banning Synthesized, Purified or Derivative Products from Kratom	Modest
234	Physician Unity in Advocacy Regarding Physician Reimbursement	Modest
235	Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities	Minimal
236	Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care	Major - To Be Determined
237	Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan	Minimal
238	Prohibiting the Independent Practice of Medicine by Artificial Intelligence	Moderate
239	Medicare Administrative Contractor Policy Modification	Moderate
240	Ending Private Equity Dividend Recapitalization in Healthcare	Moderate
241	Strengthening Our AMA Efforts Toward CPOM Prohibition	Minimal
242	Reducing Emergency Department Boarding through Payment Reform	Modest
243	Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions	Moderate
244	Eliminate Administrative Barriers to Appeal Wrongful Denials	Moderate
245	State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA	Major - $127,219 Legal analysis, creation of educational programming/module
246	Artificial Intelligence Scope of Practice	Moderate
247	Comprehensive ERISA Reform	Moderate
301	Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies	Minimal
302	Excessive Cost of Multi-State DEA Licensure	Minimal
303	Allowing Options for Certification Maintenance	Minimal

Summary of Fiscal Notes (A-26)

304	Increasing the Use of Retired Physicians in Teaching Students and Residents	Minimal
305	Leadership by Physicians for Physicians in Graduate Medical Education (GME)	Minimal
306	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows	Minimal
307	Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine	Minimal
308	Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development	Minimal
309	Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization	Modest
310	Increasing Capacity and Access to Maternal Health Services in Rural Areas	Minimal
311	Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall	Minimal
312	Advocating for Equitable Application Review in a Single Match System	Modest
313	Evaluation of Situational Judgement Tests in Medical School Admissions	Modest
314	Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education	Minimal
315	Expanding the Native Hawaiian Health Scholarship Program Eligibility	Minimal
316	Addressing Transitions Within GME Regarding Orientation Standards	Minimal
317	Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage	Minimal
401	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards	Modest
402	Strengthening Public Health Protections Against Raw Milk–Associated Illness	Major - $69,695 Development and dissemination of education initiatives
403	AMA's continued support for COVID-19 vaccination in pregnant individuals and children	Minimal
404	Develop Climate-Conscious Resources for Physicians	Moderate
405	Studying the Environmental Impact of Ambient Clinical Intelligence Use	Modest
406	Reduce Environmental Impact of Medical Journals	Modest
407	Colorectal Cancer in Alaskan Native Patients	Modest

Summary of Fiscal Notes (A-26)

408	Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality	Modest
409	Eliminate PFAS and Glyphosate in our Food and Environment	Minimal
410	Light Pollution	Minimal
411	Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control	Modest
412	Guiding Principles of Pandemic Prevention, Preparedness and Response	Minimal
413	Erosion of the Public Evidence Base for Health Policy	Modest
414	Restoring Balanced Scientific Perspective within the ACIP	Minimal
415	Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions	Modest
416	Clinical Laboratory Workforce Shortage and Sustainability	Modest
417	Respiratory Protection for Wildland Firefighters	Modest
418	Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault	Minimal
419	Examining the Impact of Circadian Disruption from Shift Work During Pregnancy	Minimal
420	Expanding Support for Women Experiencing Homelessness	Minimal
421	Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States	Minimal
422	Expanding Access to High Resolution Anoscopy	Modest
423	Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)	Minimal
424	Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)	Minimal
425	Prioritizing, Measuring, and Preventing Workplace Violence in Health Care	Modest
426	Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity (“Food is Medicine”)	Minimal
427	Infant Feeding Options for HIV-Seropositive Individuals	Minimal
428	Protecting Environmental Health Before, During, and After War	Minimal
429	Adolescent Dating Violence Comprehensive Screening Tool Development	Modest
430	Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires	Minimal

Summary of Fiscal Notes (A-26)

431	Supporting Transportation Infrastructure Reform for Public Health	Minimal
432	Addressing Public Health Risks of Online Sports Betting	Minimal
433	Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment	Modest
434	Vaccinations in Physician Offices	Modest
501	Preregistration in Medical Research	Modest
502	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care	Modest
503	Expansion of Psychedelic Assisted Therapy (PAT)	Modest
504	Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence	Modest
505	Avoiding misuse of artificial intelligence (AI) in clinical practice	Minimal
506	Access To Gender Affirming Healthcare Including Clinical Trials	Minimal
507	Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications	Modest
508	Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services	Modest
509	Preserving Gender-Affirming Surgical Care Access	Moderate
510	Exosome and Peptide Use in Healthcare	Moderate
511	Preserving Specialty Access to Anti-Cancer Agents	Modest
512	Medical Cannabis Use in Older Adults	Modest
513	Access, Affordability, and Safety of GLP-1 Receptor Agonists	Modest
514	Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy	Modest
515	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure	Modest
601	Board Chair Term Limits	Moderate
602	Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones	Minimal
603	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy	Minimal
604	Annual Scorecard to Evaluate the AMA’s Impact	Minimal

Summary of Fiscal Notes (A-26)

605	Review of Past Resolutions	Modest
606	Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	Modest
607	Shortening the AMA House of Delegates Endorsement Process and Timeline	Minimal
608	Reinstitution of AMA Guides Editorial Panel	Major - $271,952 Annual Editorial Panel funding
609	American Medical Association Board Chair Term Limits	Moderate
610	Plant-Based Diets at AMA meetings	Modest
611	Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices	Major - $252,348 Legal study, meeting planning and execution
612	Increasing Expert Guidance in AMA Statements	Modest
613	Preserving Institutional Equity and Inclusivity Efforts	Minimal
614	Inclusive Policy Language for Older Adults	Minimal
615	Condemnation of Attacks on Healthcare Workers and Facilities in Gaza	Minimal
616	Humanitarian and Medical Aid Support to Palestine	Minimal
617	Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association	Minimal
618	Ending AMA Investment in Weapons Manufacturers	Moderate
701	The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models	Minimal
702	Physicians Who Do Not Practice in Hospital Setting	Minimal
703	Parity in Pricing for Anti-Obesity Medications	Moderate
704	Advocating Against Automatic Refill Requests	Modest
705	Recognizing Physicians as Sexual Assault Forensic Examiners	Minimal
706	Discharge Summaries from Skilled Nursing Facilities	Minimal
707	Malpractice Insurance for Employed Physicians	Minimal
708	Oppose Imposition of Fees on Physicians for Electronic Payment Transfers	Modest

Summary of Fiscal Notes (A-26)

709	Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine	Moderate
710	Parity in Access to Evidence-Based Obesity Treatment	Modest
711	Oppose Denials Based on Origin of Referral	Minimal
712	Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions	Minimal
713	Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies	Moderate
714	Physician Case Log Portability	Modest
715	Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA	Moderate
716	Equal Opportunity for Payment for “On Call” Duty	Modest
717	Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse	Moderate

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Academic Physicians Section	226	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System
	307	Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
	501	Preregistration in Medical Research
American Academy of Dermatology	511	Preserving Specialty Access to Anti-Cancer Agents
American Academy of Emergency Medicine	240	Ending Private Equity Dividend Recapitalization in Healthcare
	241	Strengthening Our AMA Efforts Toward CPOM Prohibition
	242	Reducing Emergency Department Boarding through Payment Reform
	714	Physician Case Log Portability
American Academy of Family Physicians	705	Recognizing Physicians as Sexual Assault Forensic Examiners
American Academy of Ophthalmology	003	Artificial Intelligence to Bolster Physician-Led Team-Based Care
	411	Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
American Academy of Otolaryngology – Head and Neck Surgery	221	Universal Newborn Congenital Cytomegalovirus Screening
American Academy of Pediatrics	116	Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs
American Academy of Physical Medicine and Rehabilitation	239	Medicare Administrative Contractor Policy Modification
American Association of Clinical Urologists	206	Overall Hospital Quality Star Ratings / CMS Star Ratings
American Association of Neurological Surgeons	109	Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy
	309	Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
American Association of Public Health Physicians	407	Colorectal Cancer in Alaskan Native Patients
	413	Erosion of the Public Evidence Base for Health Policy
	414	Restoring Balanced Scientific Perspective within the ACIP
American College of Cardiology	426	Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity (“Food is Medicine”)
American College of Emergency Physicians	425	Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
American College of Legal Medicine	312	Advocating for Equitable Application Review in a Single Match System

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
American College of Lifestyle Medicine	219	Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
	507	Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
	508	Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
American College of Medical Genetics and Genomics	001	Ethical Guidance on Postmortem Sample Collection for Genetic Testing
American College of Obstetricians and Gynecologists	207	Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
	408	Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
American College of Occupational & Environmental Medicine	417	Respiratory Protection for Wildland Firefighters
	608	Reinstitution of AMA Guides Editorial Panel
American College of Rheumatology	118	Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs
American Geriatrics Society	614	Inclusive Policy Language for Older Adults
American Society for Clinical Pathology	416	Clinical Laboratory Workforce Shortage and Sustainability
American Society for Metabolic and Bariatric Surgery	710	Parity in Access to Evidence-Based Obesity Treatment
American Society of Plastic Surgeons	606	Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
Association for Clinical Oncology	115	Patient Continuity Protections During Payer, PBM Changes
	243	Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
	515	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure
California	227	Standby Capacity Payments and Health IT for Hospitals in Rural Areas
	228	Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
	310	Increasing Capacity and Access to Maternal Health Services in Rural Areas

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Colorado	229	Physicians are not Providers
	415	Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
Delaware	504	Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence
Florida	002	Physician Workload and Scheduling
	103	Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
	202	Using and Defining “Unsupervised Practice of Medicine”
	203	Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
	204	D-400.982 Revision
	205	Repeal of the Merit-Based Incentive Payment System (MIPS)
Georgia	222	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
	223	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
	421	Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
Illinois	111	Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia
	112	Ensuring Coverage and Access to Adult Strabismus Surgery
	232	Banning Flavored Cannabis E-Cigarettes
	233	Banning Synthesized, Purified or Derivative Products from Kratom
Indiana	005	Impersonation of a Physician
	006	Investigating Moral Injury Related to Organ Procurement Practices
	007	Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software
	107	Oversight of Medicare Advantage Plan
	224	Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
	225	Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Integrated Physician Practice Section	108	Ensuring Physician Input in the Development of CMMI Models
International College of Surgeons	234	Physician Unity in Advocacy Regarding Physician Reimbursement
International Medical Graduates Section	230	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
Kansas	218	Opposing the Practice of Jury Anchoring in Medical Liability Cases
LGBTQ+ Section	236	Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
	308	Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
	422	Expanding Access to High Resolution Anoscopy
	423	Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
	424	Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
	509	Preserving Gender-Affirming Surgical Care Access
	612	Increasing Expert Guidance in AMA Statements
	613	Preserving Institutional Equity and Inclusivity Efforts
Medical Student Section	113	Health Insurance Coverage of Hearing Devices and Related Services
	114	Opposing Alternative Funding Programs
	235	Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
	313	Evaluation of Situational Judgement Tests in Medical School Admissions
	314	Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
	315	Expanding the Native Hawaiian Health Scholarship Program Eligibility
	427	Infant Feeding Options for HIV-Seropositive Individuals
	428	Protecting Environmental Health Before, During, and After War
	429	Adolescent Dating Violence Comprehensive Screening Tool Development
	430	Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
	431	Supporting Transportation Infrastructure Reform for Public Health
	432	Addressing Public Health Risks of Online Sports Betting

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Michigan	217	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
	302	Excessive Cost of Multi-State DEA Licensure
	604	Annual Scorecard to Evaluate the AMA's Impact
	605	Review of Past Resolutions
Mississippi	210	Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
	211	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
	303	Allowing Options for Certification Maintenance
	304	Increasing the Use of Retired Physicians in Teaching Students and Residents
	305	Leadership by Physicians for Physicians in Graduate Medical Education (GME)
	704	Advocating Against Automatic Refill Requests
New England	104	Improving Choice, Competition, and Affordability in the ACA Marketplaces
	212	Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
	213	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
	409	Eliminate PFAS and Glyphosate in our Food and Environment
	410	Light Pollution
	607	Shortening the AMA House of Delegates Endorsement Process and Timeline
New Jersey	403	AMA's continued support for COVID-19 vaccination in pregnant individuals and children
	404	Develop Climate-Conscious Resources for Physicians
	405	Studying the Environmental Impact of Ambient Clinical Intelligence Use
	406	Reduce Environmental Impact of Medical Journals
	603	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
New York	105	Oppose Medicare Advantage Auto Enrollment
	214	Medical Student Loans Should Not Be Capped
	215	Oppose Medicare Efficiency Adjustments
	216	Protecting Healthcare as a Sensitive Location
	412	Guiding Principles of Pandemic Prevention, Preparedness and Response
	505	Avoiding misuse of artificial intelligence (AI) in clinical practice
	506	Access To Gender Affirming Healthcare Including Clinical Trials
	609	American Medical Association Board Chair Term Limits
	610	Plant-Based Diets at AMA meetings
	706	Discharge Summaries from Skilled Nursing Facilities
	707	Malpractice Insurance for Employed Physicians
	708	Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
	709	Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
North American Neuromodulation Society	713	Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
North Carolina	510	Exosome and Peptide Use in Healthcare
Obesity Medicine Association	703	Parity in Pricing for Anti-Obesity Medications
Ohio	220	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians
	711	Oppose Denials Based on Origin of Referral
Oklahoma	201	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
	402	Strengthening Public Health Protections Against Raw Milk–Associated Illness
Oregon	602	Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones
Organized Medical Staff Section	401	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
	611	Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Pennsylvania	102	Study for EMTALA Relief in Psychiatric Facilities
	301	Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies
	503	Expansion of Psychedelic Assisted Therapy (PAT)
	601	Board Chair Term Limits
	702	Physicians Who Do Not Practice in Hospital Setting
Private Practice Physicians Section	117	Universal Out of Network Benefits
	244	Eliminate Administrative Barriers to Appeal Wrongful Denials
	245	State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA
	246	Artificial Intelligence Scope of Practice
	434	Vaccinations in Physician Offices
	701	The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
	715	Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA
	716	Equal Opportunity for Payment for "On Call" Duty
	717	Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse
Resident and Fellow Section	009	Preserving Access to Care for Undocumented Individuals
	010	Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts
	316	Addressing Transitions Within GME Regarding Orientation Standards
	317	Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage
	615	Condemnation of Attacks on Healthcare Workers and Facilities in Gaza
	616	Humanitarian and Medical Aid Support to Palestine
	617	Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association
	618	Ending AMA Investment in Weapons Manufacturers

RESOLUTIONS – BY SPONSOR (A-26)

Sponsor	No.	Title
Senior Physicians Section	008	Senior Physicians Improving Patient Access
	110	Medicaid Coverage for Incarcerated Individuals
	231	Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
	311	Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall
	512	Medical Cannabis Use in Older Adults
Texas	237	Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan
	238	Prohibiting the Independent Practice of Medicine by Artificial Intelligence
	247	Comprehensive ERISA Reform
	433	Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment
	513	Access, Affordability, and Safety of GLP-1 Receptor Agonists
	514	Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy
Virginia	208	Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
	209	Protecting Mental Health Treatment Privacy in Legal Proceedings
Washington	101	Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”
	502	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
Women Physicians Section	004	Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
	106	Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
	306	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
	418	Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
	419	Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
	420	Expanding Support for Women Experiencing Homelessness

Reference Committee on Ethics and Bylaws

Report(s) of the Board of Trustees

02 New Specialty Organizations Representation in the House of Delegates

Report of the Council on Constitution and Bylaws

02 HOD Representation and Composition
03 Rights & Privileges of HOD Members
04 Credentialing of HOD Delegates and Alternate Delegates
05 Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
06 Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
07 HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
08 Business Meetings of the AMA Sections
09 Continuity of AMA Resident and Fellow Section Governing Council Leadership

Report of the Council on Ethical and Judicial Affairs

01 Guidelines on Chaperones for Sensitive Exams
02 Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
03 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
05 CEJA's Sunset Review of 2016 House Policies

Resolutions

001 Ethical Guidance on Postmortem Sample Collection for Genetic Testing
002 Physician Workload and Scheduling
003 Artificial Intelligence to Bolster Physician-Led Team-Based Care
004 Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
005 Impersonation of a Physician
006 Investigating Moral Injury Related to Organ Procurement Practices
007 Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software
008 Senior Physicians Improving Patient Access
009 Preserving Access to Care for Undocumented Individuals
010 Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

REPORT OF THE BOARD OF TRUSTEES

BOT Report 02-A-26

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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

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

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

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

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

RECOMMENDATION

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

Fiscal Note: Less than $500

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APPENDIX
Exhibit A

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

National Medical Specialty Societies

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

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

3) The organization must meet one of the following criteria:

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

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

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

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

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

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

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

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

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

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

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

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

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

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

Exhibit B - Summary Membership Information

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

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-26

Subject: HOD Representation and Composition

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

The AMA House of Delegates (HOD) is the policy-making body of our American Medical Association (AMA). It is democratically structured and comprised of delegates from constituent associations (state medical societies), national medical specialty societies, professional interest medical associations, the Federal services, the AMA Sections, medical student regional representatives, resident and fellow sectional representatives and other groups with HOD representation. A complete list of those represented societies is online, as is the 2026 apportionment of delegates for each. Additionally, groups represented in the HOD are invited to identify one alternate delegate for each delegate apportioned to the group.

There is parity of representation between the constituent associations and the national medical specialty societies. Each constituent association is apportioned one delegate and one alternate delegate for each 1,000 (or fraction thereof) active members of the AMA, including medical students and residents and fellows. The national medical specialty societies then receive that same number of delegates and alternate delegates and those positions are apportioned back to the individual specialty societies according to AMA Policy G-600.027. Each AMA Section and professional interest medical association granted representation in the HOD receives one delegate and one alternate delegate regardless the size of its membership. There are also two groups in our House of Delegates – medical student regional delegates and resident and fellow sectional delegates, whose apportionment is codified in the AMA Bylaws (Bylaw 2.3.2 and 2.4.2) and which is based on medical student and resident and fellow AMA membership.

While the HOD treats all delegations equally, they are constituted differently. In general, the Bylaws do not prescribe the process by which most organizations represented in the House of Delegates choose their delegates and alternate delegates. These groups have organizational autonomy and can fill their delegation positions however they choose so long as the individuals are AMA active members and members of the organization, and have autonomy when it comes to how they fill unfilled positions or vacancies. Medical students and resident and fellow physicians are eligible for service on an organization's delegation as either a delegate or an alternate delegate so long as they are AMA members and members of the organization. CCB Reports 5 and 7 provide additional details.

The Council has prepared this report to propose Bylaw amendments that further emphasize the inclusive nature of the HOD, with further nuances addressed in other A-2026 CCB reports.

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RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

2.0.1 Composition and Representation. ***

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA, including resident and fellow physicians and medical students, and of the entity they represent.

2.0.1.2 Representation. The representational role of the delegates is multi-dimensional and includes:

a. Advocacy for patients to improve the health of the public and the health care system.

b. Representation of the perspectives of the delegate's sponsoring organization to the House of Delegates.

c. Representation of the delegate's physician and medical student constituents in the decision-making process of the House of Delegates.

d. Representation of the AMA and the House of Delegates to physicians, medical associations, and others, including resident and fellow physicians and medical students.

e. Solicitation of input from and provision of feedback to constituents.

2.0.1.2.1 Consideration. In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their medical student or physician constituents. In voting on matters before the House of Delegates, delegates should vote on the basis of what is best for patients and quality medical care.

***

2.0.1.3 ~~2.8~~ Alternate Delegates. Each organization represented in the House of Delegates ~~may select~~ is allotted an alternate delegate for each of its delegates entitled to be seated in the House of Delegates. Alternate delegates must meet the criteria specified in Bylaw 2.0.1.1 and be similarly credentialed per the Bylaws that govern credentialing for the delegates representing their organization. Terms for alternate delegates shall be the same as for the delegates.

~~2.10.7~~

2.0.1.4 **Unique Representation.** No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

2.0.1.5 **Registration.** All attendees of a House of Delegates meeting must register for the meeting.

~~2.0.1.3~~

2.0.1.6 **Autonomy.** The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

2.1 **Constituent Association~~s~~ Delegations.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 **Apportionment.** The apportionment of delegates from each constituent association is one delegate and one alternate delegate for each 1,000 (or fraction thereof), active members of the AMA including medical students and residents and fellows within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 **Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. ~~**2.10.1. Notification**~~ In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

***

2.1.4 **Term.** Delegates and alternate delegates from constituent associations shall be selected for two ~~2~~-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

***

2.2 **National Medical Specialty Societ~~y~~~~ies~~ Delegations.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the

total number of delegates apportioned to constituent societies under sections 2.1.1 using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate and alternate delegate for each 1,000, or fraction thereof, physician specialty society members, including residents and fellows, as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA.

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. ~~**2.10.1. Notification.**~~ In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

***

2.2.4 Term. Delegates and alternate delegates from specialty societies shall be selected for two ~~2~~-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate and alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

***

2.6 Other Delegates and Alternate Delegates. Each of the following is entitled to a delegate and an alternate delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

***

2.6.2 Term. Delegates and alternate delegates from these entities shall be selected for two ~~2~~-year terms, and shall assume office on the date set by the entity. ***

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

2—House of Delegates

2.0.1 Composition and Representation. ***

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA, including resident and fellow physicians and medical students, and of the entity they represent.

2.0.1.2 Representation. The representational role of the delegates is multi-dimensional and includes:

a. Advocacy for patients to improve the health of the public and the health care system.

b. Representation of the perspectives of the delegate's sponsoring organization to the House of Delegates.

c. Representation of the delegate's physician and medical student constituents in the decision-making process of the House of Delegates.

d. Representation of the AMA and the House of Delegates to physicians, medical associations, and others, including resident and fellow physicians and medical students.

e. Solicitation of input from and provision of feedback to constituents.

2.0.1.2.1 Consideration. In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their medical student or physician constituents. In voting on matters before the House of Delegates, delegates should vote on the basis of what is best for patients and quality medical care.

***

2.0.1.3 Alternate Delegates. Each organization represented in the House of Delegates is allotted an alternate delegate for each of its delegates entitled to be seated in the House of Delegates. Alternate delegates must meet the criteria specified in Bylaw 2.0.1.1 and be similarly credentialed per the Bylaws that govern credentialing for the delegates representing their organization. Terms for alternate delegates shall be the same as for the delegates.

2.0.1.4 Unique Representation. No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

2.0.1.5 Registration. All attendees of a House of Delegates meeting must register for the meeting.

2.0.1.6 Autonomy. The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

2.1 Constituent Association Delegations. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate and one alternate delegate for each 1,000 (or fraction thereof), active members of the AMA including medical students and residents and fellows within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

***

2.1.4 Term. Delegates and alternate delegates from constituent associations shall be selected for two-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

***

2.2 National Medical Specialty Society Delegations. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate and alternate delegate for each 1,000, or fraction thereof, physician specialty society members, including residents and fellows, as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA.

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

***

2.2.4 Term. Delegates and alternate delegates from specialty societies shall be selected for two-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate and alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

***

2.6 Other Delegates and Alternate Delegates. Each of the following is entitled to a delegate and an alternate delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

***

2.6.2 Term. Delegates and alternate delegates from these entities shall be selected for two-year terms, and shall assume office on the date set by the entity.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-A-26

Subject: Rights & Privileges of HOD Members

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council opted to separate the issues it addressed into several focused reports.

This report presents new language to specifically address the rights of those delegates and alternate delegates who are affiliated with the House of Delegates as well as relevant HOD procedures. Current Bylaws address the rights and privileges of Ex Officio Members (of the House) [Bylaw 2.7], Rights of Official Observers (to the House) [Bylaw 2.9.1], the Rights of the Speakers [Bylaw 2.5, 4.4 and 4.5], Rights of Temporary Substitute Delegates [Bylaw 2.10.4.1] and the rights of Alternate Delegates [Bylaw 2.8], but provides no language explicitly addressing the rights and privileges of delegates. This report provides that language as well as additional amended language to address the rights and privileges of alternate delegates. It also relocates existing provisions acknowledging that a constituent association president or national medical specialty society or professional interest medical association president may be credentialed as an additional alternate delegate for the societies they represent. In doing so and in eliminating redundant text, some renumbering has occurred.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

***

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

***

2.0.1.1 Qualification of Members of the House of Delegates. ***

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2.0.1.2 Representation. ***

2.0.1.3 ~~2.8~~ Alternate Delegates. ***

2.0.1.3.1 ~~2.8.5~~ Rights and Privileges. ~~An alternate delegate may substitute for a delegate, on the floor of the House of Delegates, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials.~~ **~~2.8.6 Status.~~** The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates~~,~~ ~~n~~or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.0.1.3.2 Alternate Delegate Seated for a Delegate. ~~2.8.5~~ At the request of their corresponding delegate, ~~A~~an alternate delegate may be seated for them ~~substitute for a delegate,~~ on the floor of the House of Delegates~~, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials~~. The alternate delegate must display their corresponding delegate's temporary credential (salmon badge). While seated ~~substituting~~ for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote. ~~2.8.6~~ The alternate delegate must immediately relinquish their position on the floor of the House of Delegates at ~~upon~~ the request of ~~the delegate for whom the alternate delegate is substituting~~ their corresponding delegate.

~~**2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of the entity they represent.~~

~~**2.8.2 Certification.** Alternate delegates shall be certified to the AMA in the same manner as delegates.~~

~~**2.8.3 Term.** Alternate delegates shall be selected for a 2-year term, and shall assume office on the date set by the organization, unless otherwise provided in these Bylaws.~~

~~**2.8.4 Vacancies.** Alternate delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that term.~~

***

2.5 Speaker and Vice Speaker Additional Delegate~~s~~. Upon election of the Speaker and Vice Speaker of the House of Delegates from among the members of the House of Delegates, the organizations represented by the delegates elected to be Speaker and Vice Speaker of the House of Delegates shall be entitled to an additional delegate for the term of service of the Speaker and Vice Speaker. The additional delegates so selected shall have the full rights and privileges of delegates in the House of Delegates.

2.5.1 **Rights and Privileges** ~~**Status of Speaker and Vice Speaker**~~**.** Upon their election, the Speaker and Vice Speaker shall continue to be members of the House of Delegates, with all of the rights and privileges of members of the House of Delegates. They shall be entitled to vote in the House of Delegates. The Speaker and Vice Speaker, as members of the House of Delegates, shall be eligible to be nominated for re-election to the office of Speaker and Vice Speaker of the House of Delegates.

***

2.8 Additional Alternate Delegates.

2.8.1
~~**2.10.5**~~ **Constituent Association President.** The current president of a constituent association may also be ~~certified~~ credentialed as an additional alternate delegate at the discretion of each constituent association.

2.8.2
~~**2.10.6**~~ **National Medical Specialty Society or Professional Interest Medical Association President.** The current president of a national medical specialty society or a professional interest medical association may also be ~~certified~~ credentialed as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

***

2.0.1.1 Qualification of Members of the House of Delegates. *

/

2.0.1.2 Representation. *

2.0.1.3 Alternate Delegates. *

2.0.1.3.1—Rights and Privileges. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.0.1.3.2 Alternate Delegate Seated for a Delegate. At the request of their corresponding delegate, an alternate delegate may be seated for them on the floor of the House of Delegates. The alternate delegate must display their corresponding delegate's temporary credential (salmon badge). While seated for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates at the request of their corresponding delegate.

***

2.5 Speaker and Vice Speaker Additional Delegates. Upon election of the Speaker and Vice Speaker of the House of Delegates from among the members of the House of Delegates, the organizations represented by the delegates elected to be Speaker and Vice Speaker of the House of Delegates shall be entitled to an additional delegate for the term of service of the Speaker and Vice Speaker. The additional delegates so selected shall have the full rights and privileges of delegates in the House of Delegates.

2.5.1 Rights and Privileges. Upon their election, the Speaker and Vice Speaker shall continue to be members of the House of Delegates, with all of the rights and privileges of members of the House of Delegates. They shall be entitled to vote in the House of Delegates. The Speaker and Vice Speaker, as members of the House of Delegates, shall be eligible to be nominated for re-election to the office of Speaker and Vice Speaker of the House of Delegates.

***

2.8 Additional Alternate Delegates.

2.8.1 Constituent Association President. The current president of a constituent association may also be credentialed as an additional alternate delegate at the discretion of each constituent association.

2.8.2 National Medical Specialty Society or Professional Interest Medical Association President. The current president of a national medical specialty society or a professional interest medical association may also be credentialed as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 4-A-26

Subject: Credentialing of HOD Delegates and Alternate Delegates

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council opted to separate the issues it addressed into several focused reports.

This report presents amended language to more accurately address the appropriate credentialing authority for all groups with representation in the HOD, including the credentialing authorities for the AMA Section delegates and alternate delegates, the regional medical student delegates and alternate delegates and the resident and fellow sectional delegates and alternate delegates.

As noted in referred CCB Report 3-I-25, the Council looked at the disparate provisions that govern the credentialing of delegates and alternate delegates and noted several outmoded provisions and inaccuracies. The term "certification" referred to an obsolete process whereby each group represented in the HOD manually completed a form listing their delegates and alternate delegates and then certified the accuracy of that information. While the Council understands that the term certification may have varying implications or significance for different purposes and delegations, the term "credentialing" more appropriately reflects the current process.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2.1.3 ~~**Certification**~~ **Credentialing.** The president or chief executive officer of each constituent association, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates ~~from their respective associations. Certification must occur~~ at least 45 days prior to each meeting ~~the Annual or Interim Meeting~~ of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.2.3 ~~**Certification**~~ **Credentialing.** The president or chief executive officer of each specialty society, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates ~~from their respective societies. Certification must occur~~ at least 45 days

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prior to each meeting ~~the Annual or Interim Meeting~~ of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.3.4 ~~**Certification**~~ **Credentialing.** The ~~C~~chair of the Medical Student Section Governing Council or the director of the Medical Student Section, or their ~~Chair's~~ designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3. ~~Certification~~ Credentialing must occur at least 45 days prior to each meeting ~~the Annual Meeting~~ of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.4.4 ~~**Certification**~~ **Credentialing.** The ~~C~~chair of the Resident and Fellow Section Governing Council or the director of the Resident and Fellow Section, or their ~~Chair's~~ designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3. ~~Certification~~ Credentialing of delegates and alternate delegates must occur at least 45 days prior to each meeting ~~the Annual Meeting~~ of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.6.1 ~~**Certification**~~ **Credentialing.** The president, chief executive officer, AMA Section chair or director, or other authorized individual of each entity described in Bylaw 2.6 shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each meeting ~~the Annual or Interim Meeting~~ of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.6.2 Term. ***~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of the House of Delegates.~~

(Modify Bylaw)

CLEAN BYLAW LANGUAGE IF ADOPTED

2.1.3 **Credentialing.** The president or chief executive officer of each constituent association, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.2.3 **Credentialing.** The president or chief executive officer of each specialty society, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.3.4 **Credentialing.** The chair of the Medical Student Section Governing Council or the director of the Medical Student Section, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3. Credentialing must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.4.4 **Credentialing.** The chair of the Resident and Fellow Section Governing Council or the director of the Resident and Fellow Section, or their designee, shall provide the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3. Credentialing of delegates and alternate delegates must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

2.6.1 **Credentialing.** The president, chief executive officer, AMA Section chair or director, or other authorized individual of each entity described in Bylaw 2.6 shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 5-A-26

Subject:	Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
Presented by:	Jerry P. Abraham, MD, MPH, Chair
Referred to:	Reference Committee on Ethics and Bylaws

At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council opted to separate the issues it addressed into several focused reports.

Previously the Council had recommended deletion of Bylaw 2.1.6 that acknowledged the ability of a constituent association to include a medical or resident and fellow physician on its delegation. The Council had recommended deletion as constituent associations are autonomous and thus may select a delegate by a mechanism of its choice. However, there was significant testimony opposing deletion of that language with additional testimony supporting equivalent language for the national medical specialty societies.

This report presents updated language to reflect the HOD's will. The report also recognizes the ability of a professional interest medical association and other groups to similarly fill its delegate or alternate delegate positions with a resident/fellow physician member and/or a medical student member. Lastly, the Council acknowledges its awareness that its amended language refers to "resident/fellow physician" rather than "resident and fellow physician" as is used in other Bylaw provisions but believes the usage of "resident/fellow" is appropriate here.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2.1.2 **Selection.** Each constituent association shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

***

2.1.6 **Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates.** A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

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2.1.6.1 **Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term ~~beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA~~.

2.1.6.2 **No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two~~2~~-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.

***

2.2.2 **Selection.** Each specialty society shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

***

2.2.6 **Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates.** A national medical specialty society may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.2.6.1 **Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.2.6.2 **No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.4.

***

2.6 Other Delegates. ***

***

2.6.2 Term. ***

2.6.2.1 **Resident/Fellow Physician and Medical Student Delegates.** These entities may designate their delegate and/or alternate delegate seat to be filled by a resident/fellow physician member or a medical student member.

2.6.2.1.1 **Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.6.2.1.2 **No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

2.1.2 Selection. Each constituent association shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

***

2.1.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.1.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.

***

2.2.2 Selection. Each specialty society shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

***

2.2.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates. A national medical specialty society may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.2.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.2.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.4.

***

2.6 Other Delegates. ***

***

2.6.2 Term. ***

2.6.2.1 Resident/Fellow Physician and Medical Student Delegates. These entities may designate their delegate and/or alternate delegate seat to be

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filled by a resident/fellow physician member or a medical student member.

2.6.2.1.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.6.2.1.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 6-A-26

Subject:	Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
Presented by:	Jerry P. Abraham, MD, MPH, Chair
Referred to:	Reference Committee on Ethics and Bylaws

At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council opted to separate the issues it addressed into several focused reports.

This report covers the general parameters that govern the medical student regional delegates and alternate delegates and resident and fellow sectional delegates and alternate delegates with some proposed changes for clarity, consistency and accuracy.

BACKGROUND

Specific Requirements of the Medical Student Regional and Resident and Fellow Sectional Delegations

The medical student regional delegates and alternate delegates and the resident and fellow sectional delegates and alternate delegates are governed by long-existing American Medical Association (AMA) Bylaw provisions. The HOD in granting additional representation to medical students and residents and fellows adopted language prescribing that these representatives must be endorsed by a society represented in the HOD and be elected by their peers. The bylaws further specify that medical student regional delegates and alternate delegates require an endorsement from the constituent society in which their medical school is located and may only represent their Medical Student Region, as defined in the Medical Student Internal Operating Procedures. Similarly, there are limitations on the number of resident and fellow sectional delegates and alternate delegates that may be elected with endorsement from a single state or specialty, with those details contained in the rules (internal operating procedures) of the Resident and Fellow Section.

Current bylaws also direct that the apportionment of the medical student regional and resident and fellow sectional delegates and alternates is determined in January but does not take effect until the following January, one year later. This timing is important as it allows for the election of medical student regional and resident and fellow sectional delegates to take place in November, in conjunction with the Interim meeting. These elected delegates are then reported to the Office of the House of Delegates prior to the development of the HOD seating chart which occurs in January of each year, directly after the apportionment process for the HOD is completed. Other bylaw provisions specify that the medical student regional delegates are seated with their endorsing constituent society and the resident and fellow sectional delegates are seated with their endorsing society, hence the need to identify elected medical student regional and resident and fellow sectional delegates prior to developing the HOD seating chart for the year. These seats remain with the original delegate's endorsing society for the duration of that delegate's term (1 year). Alternate

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delegates or temporary delegates will be seated in this primary delegate's seat, even if they are from a different state within the Medical Student Region or from a different state or specialty than the original resident and fellow sectional delegate. Therefore, the Council moved the existing language that governs the seating of the medical student regional delegates and the resident and fellow sectional delegates under the heading for the medical student regional and the resident and fellow sectional delegations.

The bylaw clarifications offered in this report do not change existing rules that govern the apportionment, election, or seating of the medical student regional or resident and fellow sectional delegates and alternate delegates. The rules that govern the filling of vacancies or meeting absences in these positions are discussed in CCB 7.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2.3 Medical Student Regional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the~~ir endorsing~~ constituent association where their educational program is located. The Medical Student R~~r~~egion in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a~~ny~~ temporary delegate or temporary alternate delegate ~~form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only~~ for that region.

2.3.2 Apportionment. The total number of ~~M~~medical ~~S~~student ~~R~~regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining ~~M~~medical ~~S~~student ~~Section~~ ~~R~~regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two R~~r~~egions have the same number of active AMA medical student members, ties will be broken by lottery by the Medical Student Section Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council and the director of the Medical Student Section of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment

shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical student regional delegates and alternate~~s~~ delegates shall be elected by the medical student representatives to the appropriate Medical Student ~~Section~~ Region in accordance with rules ~~procedures~~ adopted by the Medical Student Section and approved by the Board of Trustees. ~~Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees.~~ Regional d~~D~~elegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section held in conjunction with ~~prior to~~ the Interim Meeting of the House of Delegates. Regional d~~D~~elegates and alternate delegates shall ~~be seated~~ assume office at the subsequent ~~next Annual Meeting~~ meeting of the House of Delegates.

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2.3.5 Term. Medical s~~S~~tudent r~~R~~egional delegates and alternate delegates shall be elected for one-year terms ~~and shall assume office on the date set by the Medical Student Section Governing Council~~.

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2.3.7
~~2.10.8~~ Medical Student Regional Delegate Seating. Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates, ~~substitute~~ temporary delegates, or temporary alternate delegates shall be assigned to the original medical student regional delegate's seat location during the time they are seated for the original delegate.

2.4 ~~Delegates from the~~ Resident and Fellow Sectional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional ~~physician~~ delegates and alternate delegates must be members of and have written endorsement from an ~~their endorsing~~ organization currently seated in the HOD, in a capacity appropriate to their level of training.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate and alternate delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.2.1 Effective Date. In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council and the director of the Resident and Fellow Section of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such

apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.4.3 Election. Resident and fellow sectional ~~D~~delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with rules adopted by the Section and approved by the Board of Trustees. Sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section held in conjunction with the Interim Meeting of the House of Delegates. Sectional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates. ~~Each delegate and alternate delegate must receive written endorsement from a society or organization currently seated in the House of Delegates and in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.~~

***

2.4.5 Term. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ shall be elected for one-year terms ~~and shall assume office on the date set by the Resident and Fellow Section Governing Council~~.

***

~~**2.10.9**~~

2.4.7 Resident and Fellow Sectional Delegate Seating. Each ~~delegate from the R~~resident and ~~F~~fellow ~~S~~sectional delegate shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate sectional delegates, ~~substitute~~ temporary delegates, or temporary alternate delegates shall be assigned to the original resident and fellow sectional delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

2.3 Medical Student Regional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the constituent association where their educational program is located. The Medical Student Region in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a temporary delegate or temporary alternate delegate for that region.

2.3.2 Apportionment. The total number of medical student regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining medical student regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two Regions have the same number of active AMA medical student members, ties will be broken by lottery by the Medical Student Section Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council and the Director of the Medical Student Section of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical student regional delegates and alternate delegates shall be elected by the medical student representatives to the appropriate Medical Student Region in accordance with rules adopted by the Medical Student Section and approved by the Board of Trustees. Regional delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section held in conjunction with the Interim Meeting of the House of Delegates. Regional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

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2.3.5 Term. Medical student regional delegates and alternate delegates shall be elected for one-year terms.

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2.3.7 Medical Student Regional Delegate Seating. Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates, temporary delegates, or temporary alternate delegates shall be assigned to the original medical student regional delegate's seat location during the time they are seated for the original delegate.

2.4 Resident and Fellow Sectional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Resident and fellow sectional delegates and alternate delegates must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional delegates and alternate delegates must be members of and have written endorsement from an organization currently seated in the HOD, in a capacity appropriate to their level of training.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate and alternate delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.2.1 Effective Date. In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council and the Director of the Resident and Fellow Section of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.4.3 Election. Resident and fellow sectional delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with rules adopted by the Section and approved by the Board of Trustees. Sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section held in conjunction with the Interim Meeting of the House of Delegates. Sectional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

***

2.4.5 Term. Resident and fellow sectional delegates and alternate delegates shall be elected for one-year terms.

***

2.4.7 Resident and Fellow Sectional Delegate Seating. Each resident and fellow sectional delegate shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate sectional delegates, temporary delegates, or temporary alternate delegates shall be assigned to the original resident and fellow sectional delegate's seat location during the time they are seated for the original delegate.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 7-A-26

Subject: HOD Delegate and Alternate Delegate Vacancies and Meeting Absences

Presented by: Jerry P. Abraham, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

The House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25 and Resolution 10-I-25 to CCB for a report back at A-26. CCB Report 3-I-25 proposed numerous bylaw amendments, including deletion of references to substitute delegates and temporary substitute delegates. In that report, the Council had alternatively proposed the term, "temporary delegates and alternate delegates," to denote those individuals who were credentialed to fill an unfilled seat or a delegation vacancy after the credentialing deadline, which is a uniform 45 days for all groups with HOD representation. As CCB Report 3-I-25 noted, the distinction between existing bylaw language that characterized alternate delegates, substitute delegates, substitute alternate delegates, temporary substitute delegates, and temporary substitute alternate delegate was confusing.

Resolution 10-I-25, submitted by the Medical Student Section (MSS) and the Resident and Fellow Section (RFS) asked for the following actions:

- That our AMA Bylaws be amended to explicitly affirm the ability of the RFS to appoint substitute resident and fellow sectional delegates and alternate delegates as well as temporary substitute resident and fellow sectional delegates in accordance with procedures adopted by the Section as all other delegations to the House of Delegates are able to and without being held to a higher threshold of election; and

- That our AMA Bylaws be amended to explicitly affirm the ability of the MSS to appoint substitute medical student regional delegates and alternate delegates as well as temporary substitute medical student regional delegates and alternate delegates in accordance with procedures adopted by the Section as all other delegations to the House of Delegates are able to and without being held to a higher threshold of election.

BACKGROUND

Alternate delegates are considered active members of their delegation and typically share meeting duties equally with delegates. While the traditional purpose of an alternate delegate is to be seated in the House at a delegate's request, in practice, delegations often routinely seat their alternates for the portion of the meeting covering a reference committee for which the alternate delegate was primarily responsible or for other designated times to better allow for this division of labor. Seating of alternates is accomplished via the exchange of the delegate's temporary credential (salmon card) — see CCB Report 3-A-26 (Bylaw 2.0.1.3.2). This standard practice is widely used and understood by members of the House. However, it should not be confused with the recredentialing of an alternate delegate as a temporary delegate which is reserved for delegate absences from all or the

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remainder of a meeting. Furthering this confusion is the fact that all individuals who miss the 45-day credentialing deadline for the meeting are credentialed as temporary delegates or alternate delegates for that meeting, even though they may be the duly selected individuals from that HOD entity.

In their testimony on CCB Report 3-I-25 and Resolution 10-I-25, medical students and residents and fellows cited challenges associated with school, work and family responsibilities, which often equate to an inability to attend both their Section meeting and an entire HOD meeting. They mentioned the need to hold a leadership position to secure funding to support their attendance in whole or in part, and they noted that attending the meeting in an "official capacity" such as a temporary alternate delegate may allow an excused absence from their training program. The Council heard that many medical students, residents and fellows stay for the HOD meetings for mentorship and leadership development opportunities and comprise a pool of potential temporary alternate delegates who could be appointed rather than elected. The Council noted that these "extra" medical students and residents and fellows in attendance at meetings are occasionally asked to fill temporary positions in constituent associations, national medical societies, or other groups represented in the House for which they are an eligible member. Such situations fully comport with the AMA Bylaws that allow constituent, national medical specialty society, professional interest medical associations and other groups autonomy in how to fill positions. The difficulty lies in credentialing these available individuals to fill unfilled medical student regional or resident and fellow sectional alternate delegate positions. This stems from long-existing Bylaws that require medical student regional delegates and alternates and resident and fellow sectional delegates and alternates to be elected by their respective sections and endorsed by an organization represented in the HOD.

EXAMPLES AND TERMINOLOGY

As a starting point, the Council discussed at length various scenarios that may occur before and after the credentialing deadline and proposed some definitions for clarity. These definitions will be included in the glossary of the Bylaws and cited in the House of Delegates Reference Manual: Procedures, Policies and Practices:

- ***Vacancy*** – A vacancy is a permanent loss of a position for the remainder of the term. Vacancies are addressed throughout the Bylaws where the composition of the HOD is defined.

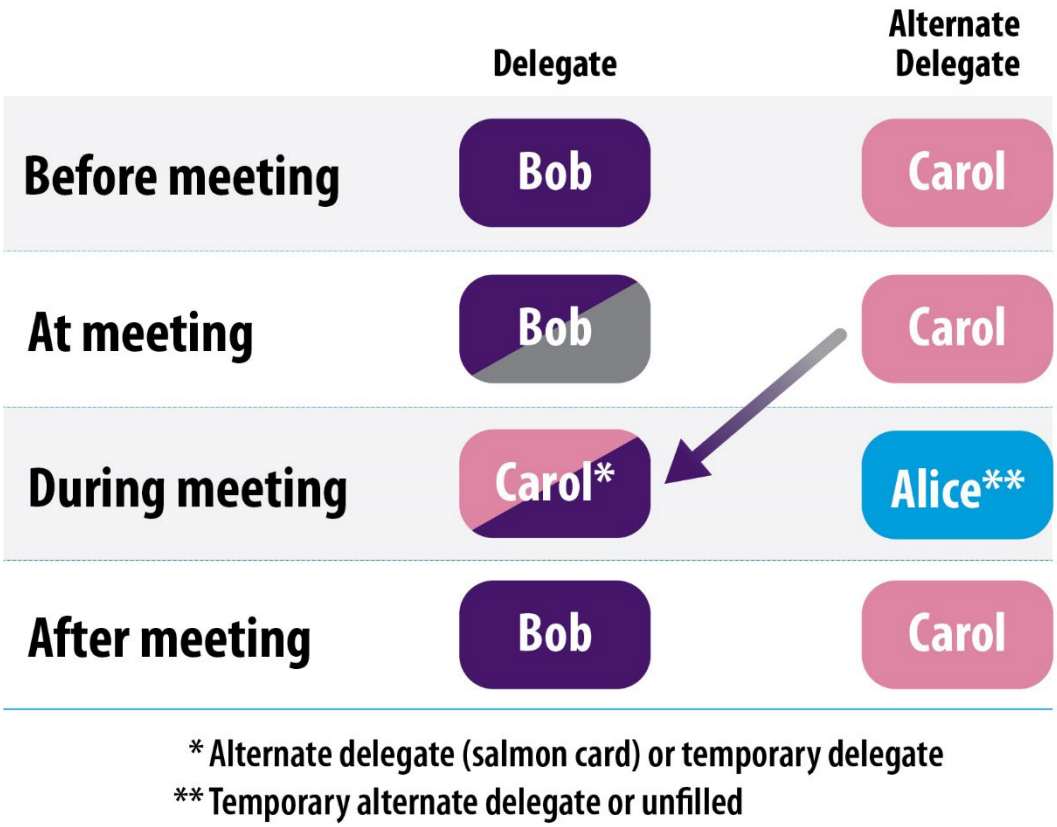
- ***Meeting Absence*** – A meeting absence occurs when a credentialed delegate or alternate delegate is unable to attend a meeting of the HOD, or a portion thereof. A remedy for a meeting absence is the credentialing of a temporary delegate or temporary alternate delegate.

Vacancies are typically addressed by filling the position via the procedures as defined by the entity represented in the House of Delegates. This may be via selection of a new individual to complete the term or to start a new term per the entity's internal rules.

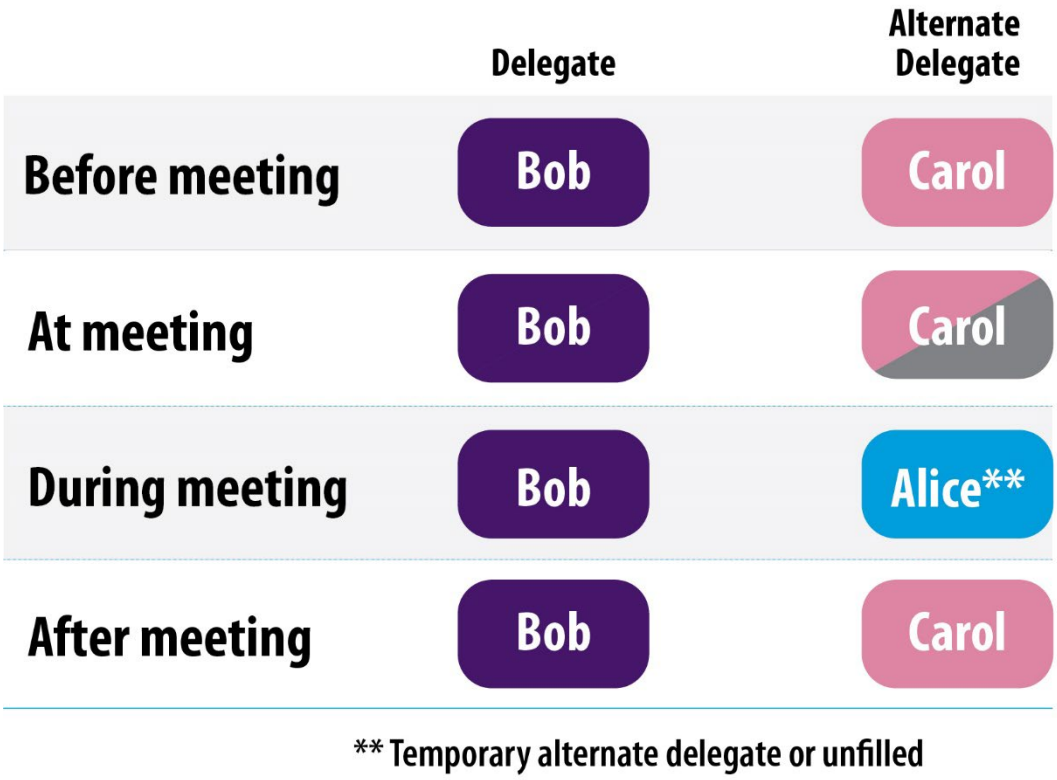
Example A: ***A Medical Association Chooses Bob as its Delegate for a 2-year Term.***
Bob duly attends an HOD meeting as a delegate but must resign shortly thereafter. The medical association then chooses, via its established procedures for filling vacancies, Carol to serve as delegate for the remainder of Bob's term.

Meeting Absences are addressed via the appointment of temporary delegates and temporary alternate delegates who fill positions that become open transiently, with the original holder of the position expected to fulfill the term. This includes occasions when the duly selected individuals were not credentialed by the 45-day credentialing deadline.

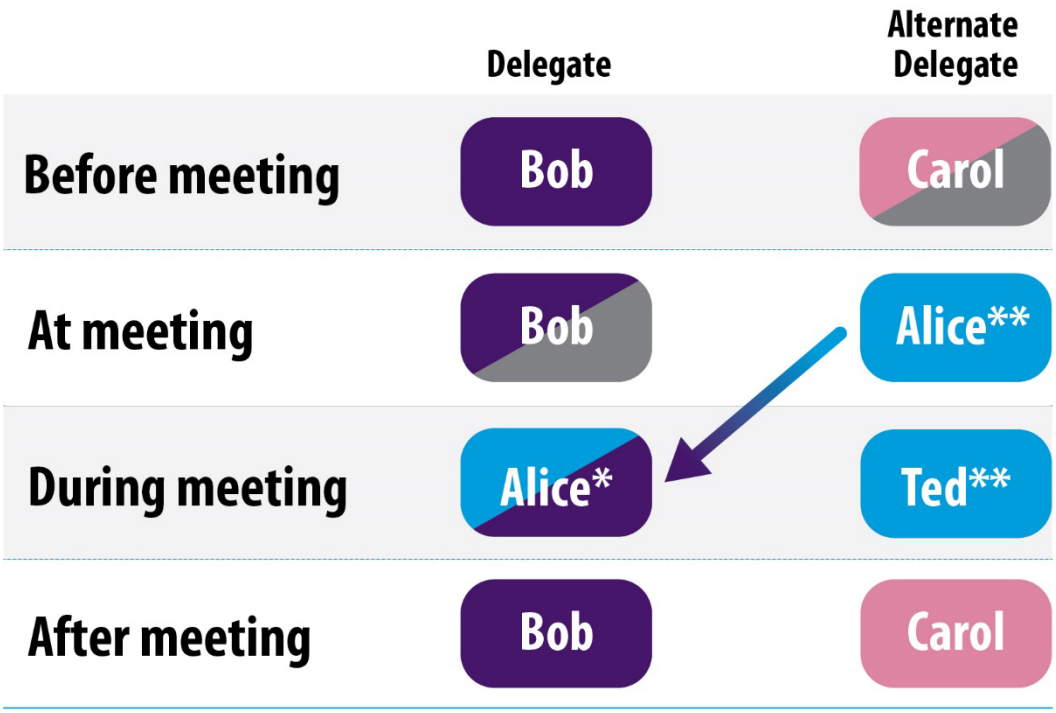
Example B*: Bob, the Delegate, Leaves the Meeting.*
A medical association has chosen Bob as its delegate and Carol as its alternate delegate. They are credentialed by the 45-day deadline. Alice, a member of the association and the AMA, attends the meeting but is not serving as a delegate or alternate delegate. Bob must leave the meeting before it concludes. Carol, the alternate delegate, may function as the delegate using Bob's salmon card, but she may not vote in elections. Alternatively, the medical association may choose to recredential her as a temporary delegate. If Carol is recredentialed as a temporary delegate, her alternate delegate position opens. This position may be left open or may be filled by credentialing a temporary alternate delegate. In this instance, the medical association chooses to credential Alice as a temporary alternate delegate for that meeting only. Following the meeting, Bob and Carol resume their roles for the remainder of their terms.



Example C*: Carol, the Alternate Delegate, Leaves Meeting.*
Bob and Carol are the medical association's credentialed delegate and alternate delegate for an HOD meeting, but Carol has to leave the meeting early. Carol's position may remain unfilled for the rest of the meeting or the association may choose to credential Alice as the temporary alternate delegate for that meeting only. Following the meeting, Bob and Carol resume their roles for the remainder of their terms.



Example D: *Bob Must Leave and Carol is Absent for the Meeting.*
Bob and Carol are the medical association's credentialed delegate and alternate delegate for an HOD meeting. Carol learns she is unable to attend, so the medical association chooses to credential Alice as a temporary alternate delegate. At the meeting, Bob learns he must leave urgently. Alice may function as the delegate using Bob's salmon card, but she may not vote in elections. Alternatively, the medical association may choose to credential her as a temporary delegate. If so, the alternate delegate position could remain unfilled, or the association could credential Ted, another eligible association member in attendance, as the temporary alternate delegate. Following the meeting, Bob and Carol resume their roles for the remainder of their terms.



CONCLUSION

The Council offers definitions of vacancy and meeting absences to clarify these two instances whereby an open seat needs to be permanently versus temporarily filled, along with the protocol to fill each. This report also standardizes the terminology governing temporary delegates and alternate delegates and clarifies the eligibility order of individuals who may be credentialed in these positions.

Lastly, this report fulfills the request of Resolution 10-I-25 by providing the necessary bylaw changes to allow for credentialing by appointment of a temporary medical student regional alternate delegate and a temporary resident and fellow sectional alternate.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaw amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of delegates present and voting following a one-day layover.

2.1.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

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2.2.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

***

2.3.6 Vacancies. A medical student who ~~The delegate selected to~~ fills a vacancy before the credentialing deadline as a medical student regional delegate or alternate delegate must be from the same Medical Student Region as the vacating student, must be endorsed by the appropriate endorsing constituent association, and must be elected by the appropriate electorate. A medical student regional delegate or alternate delegate who fills such a vacancy shall assume office immediately after ~~s~~election and serve for the remainder of that term.

***

2.4.6 Vacancies. A resident or fellow who ~~The delegate selected to~~ fills a vacancy for a resident and fellow sectional delegate or alternate delegate before the credentialing deadline must be elected by the Resident and Fellow Section and must be endorsed by an entity represented in the House of Delegates. A resident and fellow sectional delegate or alternate delegate who fills a vacancy shall assume office immediately after ~~s~~election and serve for the remainder of the term.

***

2.6.3 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

2.10 ~~Registration and Seating of Delegates.~~ Temporary Delegates and Alternate Delegates.

~~**2.10.4 Substitute Delegates.**~~

2.10.1 Temporary Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.1 When there is no delegate credentialed by the 45-day credentialing deadline, a delegate who was appropriately selected via the entity's rules may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.2 When there is no appropriately selected delegate available an alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.3 When there is no appropriately selected alternate delegate available a temporary alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.4 Temporary delegates must be credentialed the day before an AMA election in order to vote in that election.

2.10.2 Temporary Alternate Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.1 When there is no alternate delegate credentialed by the 45-day credentialing deadline, an alternate delegate who was appropriately selected via the entity's rules may be credentialed as a temporary alternate delegate for that meeting only.

2.10.2.2 When there is no appropriately selected alternate delegate available, a member of the entity who is also an AMA member may be credentialed as a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.3 Temporary Medical Student Regional Alternate Delegate. The credentialing authority for the Medical Student Section may credential a member of the Medical Student Section who has a written endorsement from their constituent association and who is from the same Medical Student Region as the absent alternate delegate as a medical student regional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate. The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

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~~**2.10.1 Notification.** In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.~~

~~**2.10.2 Credentials.** A delegate or alternate delegate may only be seated if there is certification on file stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.~~

~~**2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective entity is established, and so certified to the AMA.~~

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~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of~~

~~absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

2.1.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

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2.2.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

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2.3.6 Vacancies. A medical student who fills a vacancy before the credentialing deadline as a medical student regional delegate or alternate delegate must be from the same Medical Student Region as the vacating student, must be endorsed by the appropriate endorsing constituent association, and must be elected by the appropriate electorate. A medical student regional delegate or alternate delegate who fills such a vacancy shall assume office immediately after election and serve for the remainder of that term.

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2.4.6 Vacancies. A resident or fellow who fills a vacancy for a resident and fellow sectional delegate or alternate delegate before the credentialing deadline must be elected by the Resident and Fellow Section and must be endorsed by an entity represented in the House of Delegates. A resident and fellow sectional delegate or alternate delegate who fills a vacancy shall assume office immediately after election and serve for the remainder of the term.

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2.6.3 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

2.10 Temporary Delegates and Alternate Delegates.

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2.10.1 Temporary Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.1 When there is no delegate credentialed by the 45-day credentialing deadline, a delegate who was appropriately selected via the entity's rules may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.2 When there is no appropriately selected delegate available an alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.3 When there is no appropriately selected alternate delegate available a temporary alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.4 Temporary delegates must be credentialed the day before an AMA election in order to vote in that election.

2.10.2 Temporary Alternate Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.1 When there is no alternate delegate credentialed by the 45-day credentialing deadline, an alternate delegate who was appropriately selected via the entity's rules may be credentialed as a temporary alternate delegate for that meeting only.

2.10.2.2 When there is no appropriately selected alternate delegate available, a member of the entity who is also an AMA member may be credentialed as a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.3 Temporary Medical Student Regional Alternate Delegate. The credentialing authority for the Medical Student Section may credential a member of the Medical Student Section who has a written endorsement from their constituent association and who is from the same Medical Student Region as the absent alternate delegate as a medical student regional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate. The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 8-A-26

Subject: Business Meetings of the AMA Sections

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

In preparing its reports for the A-26 meeting of the House of Delegates and in reviewing updates to Section rules for approval by the Board, the Council has learned that existing AMA Bylaw language is confusing and constraining when referring to the Business Meetings of the AMA Sections. Some Sections have multiple business meetings prior to each meeting of the House of Delegates with components such as a virtual reference committee and elections that are accomplished electronically.

The Council has prepared this report to ensure that the AMA Bylaws remain accurate. An additional editorial change has been incorporated to reflect Bylaw 7.0.7 that states that "all rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees".

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaw amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

7.0.6 Business Meeting. There shall be a Business Meeting of members of each Section~~. The Business Meeting shall be held on a day~~ prior to each ~~Annual and Interim~~ ~~M~~meeting of the House of Delegates.

7.0.6.1 Purpose. The purposes of the Business Meeting shall be:

7.0.6.1.1 To hear such reports as may be appropriate.

7.0.6.1.2 To consider other business and vote upon such matters as may properly come before the meeting.

7.0.6.1.3 To adopt resolutions for submission by the Section to the House of Delegates.

7.0.6.1.4 To hold elections.

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7.0.6.2 Meeting Procedure.

7.0.6.2.1 The Business Meeting shall be open to all members of the AMA.

7.0.6.2.2 Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.

7.0.6.2.3 The Business Meeting shall be conducted pursuant to rules of procedure adopted by the ~~Governing Council~~ Section and approved by the Board of Trustees. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF ADOPTED

7.0.6 Business Meetings. There shall be a Business Meeting of members of each Section prior to each meeting of the House of Delegates.

7.0.6.1 Purpose. The purposes of the Business Meeting shall be:

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 9-A-26

Subject: Continuity of AMA Resident and Fellow Section Governing Council Leadership

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting of the House of Delegates Policy D-600.950 was adopted and called for an amendment to the AMA Bylaws to allow the section's Immediate Past Chair to serve in that position even if they no longer meet the membership definition of either a resident (Bylaw 7.1.1.1) or a fellow (Bylaw 7.1.1.2). Bylaw 7.1.2 states that "If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant." Bylaw 7.1.2 further provides a grace period for a Governing Council member who completes residency or fellowship within 90 days prior to an Annual Meeting. What 7.1.2 does not address, however, is an immediate past chair who during their six-month term as a nonvoting ex officio member and who completes their residency or fellowship between the Annual and the Interim Meeting. Currently, that Immediate Past Chair would be unable to continue their service on the RFS Governing Council.

The Council presents the appropriate Bylaw changes to allow the Immediate Past Chair to fulfill their term on the RFS Governing Council.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the Bylaws (shown in red and amended by insertion or ~~deletion~~) be adopted, that Policy D-600.950 be sunset, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education.
b) Members who are active duty military or public health service residents required to provide service after their internship as general medical

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officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education.
b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

7.1.2 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member completes residency or fellowship within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting. An immediate past chair who completes residency or fellowship during their term as immediate past chair shall be permitted to serve as a nonvoting ex officio member of the Governing Council for the remainder of their immediate past chair term.

(Modify Bylaws)

RELEVANT AMA POLICY

D-600.950, Amendment to AMA Bylaws to Enable Continuity of Leadership. Our American Medical Association will amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS.

CLEAN BYLAW LANGUAGE IF ADOPTED

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

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a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education.
b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education.
b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

7.1.2 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member completes residency or fellowship within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting. An immediate past chair who completes residency or fellowship during their term as immediate past chair shall be permitted to serve as a nonvoting ex officio member of the Governing Council for the remainder of their immediate past chair term.

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-26)
Guidelines on Chaperones for Sensitive Exams

EXECUTIVE SUMMARY

In this report, the Council on Ethical and Judicial Affairs considers the appropriate use of chaperones for sensitive exams, and, in general, how to create safe environments for all patients while maintaining professional boundaries. The report recommends revising Opinion 1.2.4, "Use of Chaperones" to reflect current best practices for sensitive exams. New recommendations include: (1) adoption of an "opt-out" approach for sensitive exams in routine circumstances; (2) guidance for when a physician may require a chaperone even if the patient declines; and (3) guidance for sensitive examinations and persons who cannot give informed consent, including children and adolescents.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-26

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.950, "Guidelines on Chaperones for Sensitive Exams," was adopted at the 2022 Interim Meeting and reads as follows:

> Our American Medical Association will ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in the *Code of Medical Ethics*," to ensure that it is most in line with the current best practices for adult and pediatric populations and potentially considers the following topics:
>
> a. Opt-out chaperones for breast, genital, and rectal exams.
> b. Documentation surrounding the use or not-use of chaperones.
> c. Use of chaperones for patients without capacity.
> d. Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
> e. Use of chaperone at physician request when physician deems necessary.

To fulfil this directive, the Council on Ethical and Judicial Affairs (CEJA) submitted Report 7, "Guidelines on Chaperones for Sensitive Exams," for consideration at the 2025 Annual Meeting. The report was referred with concerns expressed that the report did not adequately address certain issues such as physician safety, the economic hurdles of training and staffing chaperones, and challenges related to varying clinical scenarios, such as those posed by rural hospitals. This report includes recommendations that address these concerns.

BACKGROUND

Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the boundaries appropriate to the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, including their cultural background and beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure[1]. Efforts to provide a comfortable and considerate atmosphere for the patient during sensitive exams are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council

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draping, and clearly explaining various components of the physical examination. They also include the use of chaperones regardless of the gender of the physician or patient[2].

A chaperone is a trained professional who serves as support and a witness for a patient during an exam or procedure[1]. If the chaperone is trained to do so, they may also assist the provider with equipment and specimen handling. The use of chaperones is appropriate in a variety of specialties and clinical settings[3]. Several states have implemented legal mandates ranging in stringency from requiring that physicians offer a chaperone for sensitive examinations, to constituting any exam without a chaperone of a patient's genitals or breasts by a physician of the opposite gender as professional misconduct[4]. Physicians should therefore make themselves aware of local regulations when they consider their chaperone policy.

Having chaperones present can help prevent misunderstandings between the patient and physician and can protect the integrity of the patient-physician relationship. A fair and effective policy on the use of chaperones must balance: (1) concern for both physician and patient safety, dignity, and vulnerability; (2) respect for patient preferences; and (3) the ethical responsibility to maintain clear professional boundaries.

In most instances, only an authorized member of the health care team should serve as a chaperone and understand the responsibilities of the role. Broadly speaking, chaperones should be provided with information regarding[18]:

- Expected components of the procedures they will be observing;
- Ways to ensure patient comfort during the examination or procedure;
- Appropriate gowning or draping for privacy;
- Suitable positioning in the room such that they can assess the nature of the contact between physician and patient;
- How to intervene or stop an examination or procedure if they are concerned that the patient is distressed or that inappropriate contact has occurred;
- Reporting mechanisms for concerns and non-compliance with established chaperone policy.

Expert consensus is that individuals for whom patient care is not a routine part of their ordinary duties (such as front desk or office support staff) should not function as chaperones[1,17]. It may be appropriate for medical students, residents, and fellows to perform the duties of a chaperone, provided that special attention is paid to how these duties may be impacted by the power imbalance inherent in the trainee-supervisor relationship. Trainees should be provided with information about their role serving as a chaperone, sufficient knowledge about the procedure or interaction they will be observing, and how to report any concerns without repercussions, fear of retaliation, or other professional disadvantages.

The standard approach is to have healthcare staff (such as nurses, medical assistants or physician assistants) act as chaperones, provided they are fully trained in the responsibilities of the role. Occupying a dual role as chaperone and member of the care team is acceptable when the two sets of responsibilities do not conflict and are well understood by everyone involved. "Parents and other untrained individuals" should not act as chaperones, except in the case of young children[3,17].

Chaperones may feel uncertain or hesitant about intervening during an examination or procedure, or about reporting misconduct. To establish expectations for the role of chaperones, institutions and practices should set policies for both physicians and chaperones in advance. They should also agree

on methods of communication to signal patient distress or chaperone concerns while examinations or procedures are in progress[3].

Concerns may arise regarding the additional resources needed to implement current best practices for the use of chaperones. In particular, physicians may be concerned that these resources will be diverted away from patient care. Despite these valid concerns, it has been established that "most patients regard the offer of a chaperone as a sign of respect," and further, that chaperones can help minimize physician misconduct, which has significant detrimental effects on patient well-being, the patient-physician relationship, and the integrity of the profession as a whole[1,10]. In light of these considerations, limited resources or additional costs do not ethically justify the failure to regularly employ chaperones for sensitive examinations and procedures, and/or to make them available in other situations at the patient's or physician's request.

ETHICS ISSUES

The ethical concerns related to the use of chaperones for sensitive examinations center around the trust and trustworthiness of the patient-physician relationship. The use of a chaperone is meant to uphold respect for patients as persons and is intended as a means to recognize and protect patients' dignity, vulnerability, and autonomy. Chaperones are also important for minimizing risks to physicians as well, such as verbal or physical harassment. In addition to concerns for patient and physician safety, the need for chaperones raises other ethical concerns, such as how to appropriately train, fund, and staff chaperones. This can be particularly challenging in limited resource settings, such as rural hospitals, highlighting that ethical necessities may at times conflict with practical realities, and that the need for a chaperone is always contextually situated, making it difficult to establish clinical guidance that is able to cover all possible scenarios.

DISCUSSION

Medical examinations and procedures often require the patient to put aside their norms regarding modesty and give consent to being heard, seen, and touched in ways they would not usually allow. Therefore, it is critical to show respect to patients and foster trustworthiness. The presence of a chaperone reinforces the professional nature of the clinical interaction, with the goal of providing reassurance that the patient's experiences and concerns and the boundaries of the clinical encounter are being respected[1]. Having chaperones present can also help prevent misunderstandings between patients and physicians by clarifying expectations and facilitating communication about the examination. Chaperones should be familiar with the elements of sensitive examinations and procedures, know how to properly observe them, and know when to intervene if they have concerns. When used in this manner, chaperones may augment a patient's sense of safety by assuring the patient that the interventions are appropriate. Additionally, having a third-party present who can attest to what occurred during the encounter may protect physicians from false allegations of misconduct[1].

Mandatory, Opt-in, and Opt-Out Chaperone Policies

There are three types of chaperone policies: opt-in, opt-out, and mandatory.

- An opt-in policy is one in which patients are *automatically offered* a chaperone for sensitive examinations and procedures (the patient is informed that they can request a chaperone).

- An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive examinations and procedures (the patient is provided a chaperone, though the patient is given the option to decline, so long as the physician agrees a chaperone is not needed).
- A mandatory policy is one in which a chaperone must be present during all sensitive examinations or procedures, or else the examination or procedure will not be performed.

Currently, the AMA *Code of Medical Ethics* recommends an opt-in policy, which states that physicians should "adopt a policy that patients are free to request a chaperone and communicate that policy to patients" and that a patient's request should always be honored (Opinion 1.2.4). Under the opt-in model, the default is to proceed with the examination or procedure without a chaperone unless an explicit request for one is made by the patient. This opt-in approach provides less protection for both the patient and physician than a mandatory or opt-out approach, since the responsibility to ask for the chaperone belongs to the patient. The difficulty with this type of policy is that it assumes the patient feels empowered to ask for a chaperone without fear of damaging the patient-physician relationship or causing inconvenience or annoyance[3]. Additionally, evidence suggests that patients may not request a chaperone because they think it may insinuate that their physician is untrustworthy[10,11] and only a small percentage of patients feel comfortable asking for a chaperone when none was explicitly offered[12].

By contrast, under an opt-out policy, patients do not need to make a specific request because the policy makes it standard practice to have chaperones present for sensitive examinations. Specifically, chaperones are made available and routinely present during sensitive exams, unless the patient refuses. Opt-out policies are effective at protecting both the physician and the patient since, by default, they make it the norm to have a third-party present as a witness to sensitive exams or procedures.

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice regarding the presence of a chaperone[13]. Under ordinary circumstances, remaining silent should not be understood as valid consent.

Both opt-in and opt-out policies can create challenges in part because patients' requests and/or consent for use of a chaperone take place directly in the treatment room. For this reason, it has been suggested that patients' preferences regarding chaperones should be solicited by front desk staff or other intake staff as a routine part of the check-in procedure[11,4]. This is an opportunity to provide materials explaining the purpose of the chaperone and to inform patients of the standard policy while allowing patients to express their preferences in a low-pressure environment. However, regardless of where and how consent for the use of a chaperone is solicited and obtained, physicians should keep in mind that what is most important during "the process of obtaining informed consent is equalizing the patient's ability to say *yes* or *no*"[6].

Documentation of Chaperone Use

Regardless of the chaperone policy implemented in a particular setting, the medical record should document the presence or absence of a chaperone for each sensitive examination[1,3,11]. For all examinations or procedures in which a chaperone is present, the medical record should reflect whether the patient requested a chaperone explicitly or whether one was present as a matter of policy. Additionally, the name of the chaperone present and any patient preferences regarding the use of a chaperone should also be documented. Note that there is a range of acceptable practices for

recording chaperone information and therefore, the extent of documentation, including what precise data to include, varies among medical specialties.

Patients with Diminished or Lacking Decisional Capacity

It is widely agreed that patients who are unable to give informed consent should always have a chaperone present for sensitive examinations and procedures. These patients might be unconscious, sedated, or have cognitive impairments or severe mental illness[9,2,3]. When treating adult patients who have diminished capacity or lack capacity to consent, it is imperative to have a trusted companion, social worker, caregiver, or group home escort present alongside the chaperone, to ease any potential patient distress[3]. It should be made clear that chaperones are mandatory in these circumstances.

Patient Preferences Regarding Chaperones

With regard to patients' preference for specific characteristics of a chaperone (such as gender or religious affiliation), physicians should be respectful of the patient's values and preferences while also being mindful not to accede to discriminatory or disruptive patient demands. Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship while also creating an "environment that strains relationships among patients, physicians, and the health care team." (Opinion 1.1.2) Discriminatory requests should not typically be accommodated, and accommodation should only occur after careful weighing of the circumstances. Patients' preferences, if nondiscriminatory, should be respected, documented, and upheld within reason and feasibility.

The Use of a Chaperone at Physician Request

There may be times when the physician deems the use of a chaperone necessary. In such cases, if the patient declines, the American College of Obstetricians and Gynecologists (ACOG) suggests that the physician should explain that "the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible"[1]. Ideally, these conversations will be a process of joint decision-making between the patient and the physician. If the patient declines a chaperone when the physician determines having a chaperone present is clinically indicated, every effort should be made to accommodate the preferences of the patient, consistent with the requirements of patient safety, physician safety, and the maintenance of professional boundaries. Physicians should inquire about specific concerns the patient may have and suggest ways these might be addressed in a mutually acceptable manner. Physicians should engage the patient in a detailed discussion of how care might be provided in a way that maintains a comfortable and respectful environment before deciding that they cannot perform the exam or procedure. If the examination is ultimately performed without the use of a chaperone, the rationale should be documented[1]. As a last resort, if the patient and physician cannot come to an agreement, then the physician may defer the examination or procedure and refer the patient to another clinician. In this situation, patients should be provided with "reasonable assistance in making alternative arrangements" so they can receive care in a timely fashion (Opinion 1.1.3).

The Use of a Chaperone without Patient Consent in Exceptional Circumstances

In some situations, insisting on a chaperone when the patient declines may violate the patient's autonomy and therefore be impermissible. However, physicians may proceed with the use of a chaperone without the expressed consent of the patient in the following circumstances:

- When it is an emergency and failure to proceed rapidly would result in an immediate risk to the patient's life or long-term health, or
- In cases where the integrity of the patient-physician relationship is at risk, such as when a patient's behavior compromises (or has previously threatened or crossed) professional boundaries, or the physician has reason to believe such a boundary violation or other unsafe situation is likely to occur.[14]

Pediatric & Adolescent Patients

Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from adult patients because they have different needs and sensitivities. Normally, a parent or guardian may act as the chaperone for young pediatric patients (from newborns to age 11)[15]. In cases where a parent or guardian is unavailable or their presence would interfere with the examination (such as in cases of suspected abuse), another chaperone should be present[15]. Should a parent or guardian decline the physician's request that a chaperone be present in such situations, it may nevertheless be appropriate for the physician to insist that a chaperone be present for the sake of patient safety.

Addressing the needs of adolescent patients (age 12-17) is more complex. Since many adolescents are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for increased privacy," any examination that requires them to remove their clothes could be distressing[12]. Physicians should not assume that their own definitions of a sensitive examination reflect the understanding of the individual teenage patient[16]. Research shows that 60-70 percent of female adolescents would like the option of a chaperone for both standard and sensitive examinations. Only 21 percent indicated that they would ask for a chaperone if one was not offered, and substantially more female adolescents wanted a chaperone for sensitive examinations if they had a chaperone in the past[12].

Many adolescents want a parent to act as chaperone instead of a healthcare professional, although in general as their age increases their preference for a non-parent chaperone also increases[16]. Some adolescents do not wish to have chaperones, indicating that it would be more embarrassing, awkward, or uncomfortable to have an additional person in the room[11].

As such, when treating adolescents, the best policy is to explain the role of chaperone in detail and then solicit their preferences. It is also important to ask whether they wish to have their family member or guardian in the room, either in addition to, or instead of, the healthcare professional acting as chaperone. Since adolescents may not have prior experience with chaperones, it is probably not sufficient to have them fill out a form at intake. Instead, their options should be presented during a conversation (and, if they wish, with a parent or guardian present) so a decision can be made together. Their preferences are also likely to change over time, so this conversation will need to be revisited.

As noted in Opinion 2.2.1 "Pediatric Decision Making," the "more mature a minor patient is […] the stronger the ethical obligation to seek minor patients' assent." This obligation extends to their assent for the presence of a chaperone, as well as their preferences for who the chaperone will be and the gender of the chaperone. In general, physicians and parents/guardians should respect a

minor's refusal to assent to a chaperone (except under the exceptions outlined above when a physician may either insist or may decline to proceed with the examination for emergency or safety reasons).

Policies around the use of chaperones for adolescents are separate from issues of parental consent for treatment. Physicians should be aware that in some jurisdictions, "the law permits minors to receive confidential services relating to contraception, or to pregnancy testing, prenatal care and delivery services" or to prevent, diagnose, or treat sexually transmitted disease without parental consent and/or notification (Opinion 2.2.2). Once the legally required consent has been obtained, the minor patient's preferences concerning use of chaperones can be discussed[17].

ETHICS ANALYSIS

There is a power imbalance embedded in the patient-physician relationship. Patients make themselves vulnerable to the physician both by permitting procedures and examinations to be conducted on their bodies and by disclosing private information to the physician during the course of the clinical encounter. The physician guides the care that the patient receives and should adopt practices within the clinical encounter to foster trustworthiness. The presence of a trained chaperone during sensitive examinations contributes to establishing trust between physician and patient, as knowing that the encounter has been witnessed provides everyone involved with reassurance that the encounter was professional and safe.

Appropriate use of chaperones during sensitive examinations and procedures is meant to protect both the physician and the patient. Having a chaperone present can increase trust between the physician and patient, contribute to the comfort and safety of the patient, and help maintain the patient's dignity. The use of chaperones can also help protect the physician against accusations of misconduct that arise from misunderstandings or that are intentionally false.

Chaperones are responsible for upholding the patient's privacy and confidentiality; however, because physicians are obligated to "seek to protect privacy in all settings to the greatest extent possible" (Opinion 3.1.1), opportunities should be provided for private conversation with the patient without the chaperone present. In addition, physicians should minimize inquiries or taking a patient's history during a chaperoned examination or procedure. If a patient shares information with the chaperone that is relevant to patient care but requests that this not be disclosed to the physician, the chaperone should make it clear that they cannot maintain confidentiality when doing so would endanger the health of the patient. The chaperone may also encourage the patient to either raise the issue with the physician themselves or obtain permission from the patient to communicate the information to the physician separately.

What is considered a sensitive examination or procedure can vary widely among patients. In order to foster trust between the patient and physician and to set appropriate professional boundaries for sensitive examinations and procedures, various factors affecting the particular patient should be considered, including history of trauma, sexual orientation, gender identity, personal beliefs, and cultural norms and expectations.

Since patients may not disclose their history of sexual assault or previous negative healthcare experiences, trauma-informed care (sometimes alternatively described as "healing centered engagement")[5] should be employed for all examinations, including those not usually understood as sensitive. A trauma-informed framework "assumes that all people have experienced trauma, are experiencing it, or may experience it in the future"[6]. This approach is focused on creating "safety, empowerment and trustworthiness" in the clinical encounter[7].

For sexual and gender minority patients, their lived experiences, perspectives and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive[7]. Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient's level of comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for all patients is to be open to broadening the range of circumstances in which a chaperone is used.

The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate behavior[1]. Patients may be more comfortable with someone of a particular gender being present because that person can better understand the kinds of embarrassment or discomfort associated with their sensitive exam and so may be better equipped to provide support[8].

While opt-in chaperone policies have historically been regarded as adequate, this is no longer the case for some specialties. There is evidence that a shift to opt-out policies will better protect both patients and physicians in many settings. ACOG argues that given "the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone" regular use of chaperones is necessary to assure patients and the public that significant "efforts are being made to create a safe environment for all patients"[1]. Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Similarly, the American College Health Association supports the adoption of opt-out chaperone policies and recommends that every medical institution have a policy regarding sensitive examinations "to protect patients' safety and minimize risk associated with the performance of these exams" that should include the presence of a chaperone for such exams[18].

Physicians deserve to work in an environment where false allegations of misconduct or misunderstandings between physicians and patients do not compromise either their professional reputation or the relationships of trust that they have established with their patients. Likewise, patients deserve to be treated in an environment that supports their agency and improves the quality of their experience, without being expected to make a special request. These goals are best promoted through the implementation of an opt-out policy for the use of chaperones during sensitive exams. Therefore, the presence of chaperones should be standard during sensitive exams and procedures. In other situations, it is recommended that chaperones be made available if the patient requests one. While not mandatory for every clinical encounter, patients should be made aware that they have a right to request a chaperone for any examination. Finally, physicians should honor patients' preferences for a chaperone even when a trusted companion is present.

CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that the use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Chaperones must be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient. As far as possible, lines of authority in the

reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter[3]. Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care. While there are valid concerns related to funding, training, and staffing chaperones, these challenges do not supersede the ethical obligation to provide a chaperone to patients during sensitive examinations and procedures. If physicians feel that they cannot uphold this ethical obligation, they should work with their administrators and specialty associations to remedy the situation.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed:

1. Opinion 1.2.4 "Use of Chaperones" be amended by deletion and addition as follows:

   Chaperones should be authorized members of the health care team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.

   Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clearly explaining various components of the physical examination, and the use of ~~having~~ a chaperone~~ available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure.

   Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, Physicians should:

   (a) Provide a chaperone for all sensitive exams, regardless of patient capacity, unless the delay in obtaining a chaperone would result in significant harm to the patient.

   (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam.

      i. If the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician.

      ii. In emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale.

~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~

~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~

~~(e)~~(c) Minimize inquiries or history taking ~~of a sensitive nature~~ while a chaperone is present.

(d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries.

(e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician.

All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk.

For non-sensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request.

(Modify HOD/CEJA Policy)

2. Policy D-140.950 be rescinded as it has been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-26

Subject:	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
Presented by:	Rebecca Brendel, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

AMA policy D-140.946, "Managing Conflict of Interest Inherent in New Payment Models," adopted at the 2025 Annual Meeting, and asks the following:

> Our AMA will produce a report with the aim of updating our *Code of Medical Ethics* to include guidance on disclosure of financial arrangements between physicians and healthcare facilities, employers, or payors that are potentially against patients' best interests.

This report is submitted for the information of the House of Delegates in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician disclosure of financial arrangements.

BACKGROUND

Health care in the United States is currently undergoing a transition in the way systems approach payment and reimbursement for health care services. While, traditionally, health care payment has been based on the volume of services provided (fee-for-service models), alternative models of payment (such as value-based care models) are increasingly being adopted throughout the U.S. due to concerns regarding the lack of equity and focus on patient-centered care that has become endemic with fee-for-service models.[1] Many health care organizations welcome this transition, though proponents of fee-for-services models assert that value-based care also has issues and that we are better off realigning incentives within fee-for service models.[2] Other major shifts in the health care payment landscape include the rise of venture capital and private equity firms' increasing investment in, and acquisition of, physician practices and hospitals;[3] new and emerging technologies, such as personalized medicine and the use of AI tools within medicine, which are adding new complications to financial and reimbursement models;[4,5] and payments to physicians from industry, which remain pervasive despite evidence that such payments may influence clinical decision-making and negatively impact trust in the patient-physician relationship (though payments vary widely both within and between specialties).[6] As financial arrangements between physicians and healthcare facilities, employers, and payors continue to evolve, physicians must strive to ensure that such payment models and financial incentives do not conflict with or prohibit them from upholding their ethical and professional obligations to patients.

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ETHICS ISSUES

Physicians have an ethical obligation to prioritize patient welfare over financial incentives; thus, payment models potentially create dual loyalties and conflicts of interest if they encourage physicians to prioritize costs and revenue over patient care. A primary mechanism to protect patients, physicians, and trust in the institution of medicine is through the disclosure of any financial arrangements or other similar factors that could impact patient care. As payment models and financial arrangements become increasingly complex and challenging for patients to understand, there is an ever greater need for physicians to be aware of and understand their ethical obligations related to the appropriate disclosure of these financial arrangements, including how to uphold professionalism, informed consent, transparency, and quality care.

ETHICS ANALYSIS & RELEVANT *CODE* OPINIONS

The AMA's *Code of Medical Ethics* is not blind to the potential dangers posed by payment models and financial incentives. Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges that such models "can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient."[7] The opinion provides specific guidelines for physicians in leadership positions within health care organizations, and for the profession as a whole, on how organizational structures, payment models, and decision-support tools should be implemented to minimize the risk of unethical behavior.

The *Code* includes several other opinions that provide guidance to physicians related to financial arrangements and the importance of disclosing such arrangements. Opinion 11.2.2, "Conflicts of Interest in Patient Care," states that physicians must never "place their own financial interests above the welfare of their patients" and that regardless of the economic interests of any health care entity, if such interests "are in conflict with patient welfare, patient welfare takes priority."[8] This foundational ethical obligation of physicians to prioritize patient care over profits is echoed in Opinion 11.2.3, "Contracts to Deliver Health Care Services."[9] The opinion includes recommendations for physicians to thoroughly review contract terms, avoid conflicts of interest, ensure financial stability, maintain clinical independence, and ensure transparency.

With regards to the importance of maintaining transparency, Opinion 11.2.4, "Transparency in Health Care," states that "physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives, and formularies".[10] The opinion also states that physicians should "[d]isclose any financial and other factors that could affect the patient's care."[10] In essence, this opinion makes it clear that financial disclosure, including disclosure of payment models or other financial incentives that may impact patient care, is a fundamental ethical responsibility for physicians. Additionally, the notion regarding the importance of disclosure is supported by Opinion 2.1.1, "Informed Consent," which highlights the value of transparent communication in fostering trust and shared decision-making. Taken together, these opinions require that physicians inform patients of all medically appropriate treatment options and that they disclose existing financial incentives or payment models that impact care decisions.[11]

CONCLUSION

The increasing corporatization of medicine, and the associated consolidation of health care entities, has been met by the emergence of new payment models in response to these changes. Despite shifts in payment models, it is crucial to recognize that any payment model has the potential to create conflicts of interest. Important steps to minimize such risks include prioritizing patient care above financial interests, supporting transparency through financial disclosure, and practicing informed consent and shared decision-making, as outlined in the *Code of Medical Ethics*.

RECOMMENDATION

The Council on Ethical and Judicial affairs recommends that Policy D-140.946 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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REPORT 03 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-26)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

EXECUTIVE SUMMARY

In adopting Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," the House of Delegates requested that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

Although not all collective actions by physicians may impact clinical practice, the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible. The ethical dilemma is whether physicians can prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit. To respond to these issues, CEJA recommends amending Opinion 1.2.10, "Political Action by Physicians," to more clearly articulate that disruptive collective actions that would likely harm patients are to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions may be considered if non-disruptive actions fail, though such actions should not directly compromise patient care and the aim of such actions should be to improve patient care and not primarily for physician self-interest.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-A-26

Subject: Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Council on Ethical and Judicial Affairs (CEJA) Report 8, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was introduced by CEJA at the 2025 Annual Meeting and was referred. CEJA Report 08-A-25 responded to Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," which was adopted at the 2023 Annual Meeting and asks the following:

1. Our American Medical Association will reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally.

2. Our AMA will request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

The House testified against the word "could" in recommendation (c) of CEJA Report 8-A-25, noting that its use is too broad, nonspecific, and might restrict physicians' ability to take collective action. CEJA appreciates that the use of "could" created an insurmountable bar, and so as a result, in recognition of physicians' fiduciary duties and the need for physician advocacy, CEJA has reached a balance by changing "could" to "would likely" in recommendation (c) for greater clarity. At the 2025 Interim Meeting, the House again referred the report and voiced comments directing CEJA to edit specific language, this time requesting that the use of "could" in recommendation (e) be amended to mirror the new language of "would likely" in recommendation (c).

While in the I-25 report, recommendation (c) pertains to all forms of collective actions, recommendation (e) is specific to disruptive collective actions that could directly compromise patient care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Disruptive collective actions are thus more likely than non-disruptive actions to cause harm to patients and therefore necessitate a higher ethical burden to be justified, as outlined in recommendations (d) and (e). The Council has discussed the different language used in the I-25 report recommendations and believes that the use of "could directly" in recommendation (e) best describes the reality of disruptive collective actions and correctly reflects physicians' ethical obligations. However, to help clarify this hierarchy of ethical burden, recommendations (c), (d), and (e) of the I-25 report have been reorganized as subsections i, ii, and iii, respectively, under

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recommendation (b) in this report. Recommendation (e), now iii, has also been revised to better reflect physicians' primary ethical obligation to patient welfare (ahead of other considerations including their own self-interest or obligations to others) and the potential for disruptive collective actions that could directly compromise patient care to interfere with this duty. The Council also wishes to highlight that the use of "should" is not a prohibition and does not mean physicians must never engage in such actions. The recommendations presented in this report do not prohibit physicians from striking but rather lay out the ethical obligations under which such disruptive collective actions could take place.

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities.[1] Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019.[2] As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1 percent of practicing physicians.[1] Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

As the financing, organization, and leadership of the health care system change, the practice environment increasingly makes it challenging for physicians to provide the kind of care patients want and deserve. Physicians are now increasingly held to strict performance metrics that many feel are more about meeting corporate financial goals than they are about providing quality patient care. As a recent New York Times article puts it, "longer-term consolidation of health care companies has left workers feeling powerless in big bureaucracies. They say the trend has left them with little room to exercise their professional judgment."[3] There is a growing sense among physicians that current working conditions are increasingly compromising the patient–physician relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and retirement from medicine.

Unions are seen by some as a mechanism for physicians to exert influence on corporate health systems where physicians have less autonomy than in private practices.[4] Unions' power for collective bargaining comes from their ability to organize members to take collective action. Unionization, however, is not the only means by which physicians can organize and take collective action. Hospitals' organized medical staff has been a means by which physicians have exercised authority over decision making and culture, but the authority and scope of responsibility of the organized medical staff has been limited.[5] While employed physicians in large systems have not typically explored re-invigorating the organized medial staff, this remains an alternative means by which physicians can reclaim lost authority and exercise collective action.[5]

Physicians may undertake many forms of collective action, both in the public arena and within health care institutions. Public actions include, but are not limited to, public advocacy, media campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting increasingly are being considered as additional forms of collective action, particularly to effect change in specific clinical environments. Some of these are not disruptive, such as negotiation with

administrators. Disruptive actions are also being considered, such as picketing, refusal to comply with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A primary concern surrounding the use of these disruptive collective actions by physicians in the clinical setting is that some of these actions may impact patient care and thus be in direct conflict with physicians' professional and ethical duties to not abandon patients and to prioritize patient care above self-interest.[6]

Relevant Laws

In 1935, Congress passed the National Labor Relations Act (NLRA), amended in 1947 through the Taft-Hartley Act, which guarantees private sector employees the right to unionize, engage in collective bargaining, and take collective actions such as strikes.[1] The NLRA covers most private sector employees but does not cover independent contractors, supervisors, or managers. Part-time physicians working as independent contractors, physicians in private practice, and physicians considered to serve a supervisory role, such as medical directors or tenured medical faculty, are currently excluded.[2]

When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit hospitals, it added Section 8(g), requiring health care employee unions to give at least a ten-day notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to make appropriate arrangements for the continuity of patient care in the event of a work stoppage.[2]

Laws prohibiting the corporate practice of medicine are an under-appreciated mechanism for physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s that prohibit the corporate practice of medicine, but little attention has been paid to the potential use of such laws to prevent health care institutions from infringing upon the clinical decision-making authority that properly belongs to physicians.[7]

Relevant AMA Policy Provisions

In 2019, the AMA modified two relevant policies: H-385.973 "Collective Negotiations" and H-385.976 "Physician Collective Bargaining."[8,9] Both support the right of physicians to engage in collective bargaining and express the AMA's commitment to work for the expansion of which physicians are eligible for that right under federal law. This includes supporting efforts to narrow the definition of supervisors such that more physicians are protected under the NLRA.
Though not policy, the AMA's Advocacy Resource Center has also issued a recent Issue Brief: "Collective bargaining for physicians and physicians in training" that outlines AMA policy on physician unions and collective bargaining, including the interpretation that the AMA's position is that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care."[2]

Relevant Code *Provisions*

The AMA *Code of Medical Ethics* Opinion 1.1.1, "Patient-Physician Relationships," states that the core tenets of the clinical encounter for the physician are "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the primary ethical duties of physicians to prioritize patient care and regard their responsibility to the patient as paramount. The Principles enumerated in the Code also indicate that such duties extend

beyond the bedside and that physicians have a responsibility to seek changes to laws that are contrary to the best interests of the patient.

Opinion 1.2.10, "Political Action by Physicians," currently states that not only *can* physicians seek to change policies or laws that they find contrary to the best interest of patients but they in fact *have* an ethical duty to do so, though they also "have a responsibility to do so in ways that are not disruptive to patient care."[10] While the opinion states that "[s]trikes and other collective actions […] should not be used as a bargaining tactic", it also adds that "[i]n rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care."[10] However, this permissibility must be balanced by the opinion's first directive that physicians participating in advocacy activities should "[e]nsure that the health of patients is not jeopardized and that patient care is not compromised."[10]

This is in line with Opinion 1.1.6, "Quality," which states that "[a]s professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable."[11] Taken together, by stating that "physicians have an ethical responsibility to seek change" at times (Opinion 1.2.10) and that they also have an "obligation to ensure" quality care (Opinion 1.1.6), these opinions highlight the fact that certain conditions may arise that actually demand action be taken by physicians to improve patient care.

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised.[12] The opinion stipulates that physicians have a responsibility both individually and collectively to ensure and promote health and wellness among physicians, and that when their health or wellness is compromised, individual physicians should fulfill this responsibility by "taking measures to mitigate the problem."[12] Physician health and wellness is necessary for effective healing and the provision of quality care, and collective action may be an appropriate means of securing institutional conditions that are conducive to patient health and well-being.

Additional Relevant Policy

The World Medical Association recommends that physicians adopt the following guidelines regarding collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.
3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care.[13]

ETHICAL ISSUE

What are the ethical considerations regarding participation in collective labor action by physicians? Since certain collective actions can be disruptive, they present a potential risk to patient care and thus create a dilemma for physicians, particularly when collective actions may create immediate risks to patients, even if intended as a means to improve patient care in the long term. What collective actions by physicians are ethically permissible must be examined to ensure that the primacy and quality of patient care are protected. The core ethical issue is whether physicians who embrace tactics used by organized labor will also still be able to embrace their role as professionals.

REVIEW OF RELEVANT LITERATURE

While not all collective actions by physicians may impact clinical practice, disruptive actions such as strikes result in practical challenges to clinical care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Some of these actions may have the potential to decrease quality of care and cause patient harm.

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable.[6,13,18,19,20] However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income.[6,18]

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognizes physicians as laborers with all the rights of laborers, while drawing limits that protect the public from harm.

A second line of argument is a variation on this first line of argument—asserting that while medicine is ideally construed as a profession with intrinsically special rights and obligations, one must now, however reluctantly, accept the de-professionalization of physicians as a socioeconomic and historical fact. On this view, physicians have been forced out of their professional status by changes in the financing and organization of health care and the only available means of asserting power now is through unionization and the means of negotiation that have been used for the last two centuries by other workers in resolving disputes with their employers. Again, the operative ethical question becomes one of setting limits on these actions in accord with the vital nature of the service physicians provide.

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large health care systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if impediments to good patient care are sufficiently serious, and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short-run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified.[6,19] These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed, and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived, or, at least, difficult for the public to believe.[6,19,21]

Others have held that strikes by physicians are almost never justifiable.[22-24] Strikes by physicians raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

> Whatever justification they may have, strikes or "slow downs" by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the medical profession has thus been compromised by physicians themselves. Those who choose to pursue self-interest, as union members may, cannot at the same time demand a superior moral position in society.[22]

Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle that the duty to promote the good of the patient is always paramount, and that strikes will always harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to disrupt care, inconvenience, or possibly harm patients, even if minimally, in order to pressure administrators into acceding to the demands of the striking physicians. Even granting that the ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the short run, and this conflicts with the profession's ancient duty to protect patients from harm.

Moreover, opponents take issue with the consequentialist argument that some patients could justifiably be exposed to potential harms now for the sure benefit of others in the future. They argue that a primary principle of ethics is that persons should always be treated as ends in themselves and never as means only. Physician strikes, by their nature, instrumentalize some patients, using their potential harm as means of achieving physicians' ends, even if those ends are justifiable and good.

Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the glue that holds the patient-physician relationship together. The sense that one's own health as a patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in the profession.

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care,[25-28] much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.[26,27] Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator

of deleterious change in patient health outcomes.[25] Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain[28]. This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution.[29]

ETHICAL ANALYSIS

In its review of Opinion 1.2.10, "Political Action by Physicians," CEJA has examined the ethics of collective actions by physicians. While the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical dilemma is whether physicians can, in fact, fully understand themselves as professionals called to prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit.

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the health care sector has seen an increase in the complexity of health care systems, the transition to a majority physician employment structure, and as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other non-physicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

The result is a general loss of control over practice conditions that have driven dissatisfaction, burnout, and early retirement from the profession. However, the issue is not necessarily employment itself, but the associated loss of independence of clinical practice and control over the clinical environment, which many today see as the de-professionalization of medicine.

For those seeking to maintain and restore physician authority and independence, the primary avenue has been to pursue legal and political actions, such as lobbying (either independently or through medical associations). However, with the change towards physician employment, physicians are now considering the use of tools that laborers have historically relied on for negotiating, such as legally permissible collective actions, in their attempts to improve patient care. This acceptance of the tools of organized labor, however, is in tension with medicine's self-understanding and public representation of itself as a profession with distinct privileges granted by society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are not likely to violate the norms of medical professionalism[30]. Disruptive collective actions, however, which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the medical profession's fundamental duty to do no harm and care for patients. Any disruptive collective action that causes harm to patients is inherently inconsistent with the responsibilities and duties of physicians.

Disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are

therefore to be avoided. This does not mean, however, that all forms of disruptive collective action must be avoided. Certain forms of disruptive action, such as collective refusal to comply with administrative directives that are understood as antithetical to good patient care or otherwise incompatible with the norms of professional ethics, may be ethically justified. Other forms of disruptive action that are aimed at disrupting administrative processes such as billing but do not disrupt service to patients, might also be justified. Disruptive actions should only be undertaken, however, as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted. Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

Physicians thinking about participating in disruptive collective actions therefore must first consider their professional responsibilities and obligations.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:

1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:

   Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

   Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy.

   Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians,

promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.

When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions:

(a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing.

(b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.

(i) Physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care.

(ii) Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

(iii) Physicians should avoid disruptive collective actions that could directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest.

(c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients.

(d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities.

2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-26

Subject: CEJA's Sunset Review of 2016 House Policies

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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 (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.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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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 Ethical and Judicial Affairs 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. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-370.985	Organ Donation	Our AMA will study potential models for increasing the United States organ donor pool.	Retain; remains relevant.
G-600.130	Meeting Calendar and Locations	AMA policy on the meeting calendar for the House includes the following: (1) Our AMA should make reasonable efforts to avoid scheduling future Annual Meetings that conflict with Father's Day weekend; (2) The Interim Meeting of the House of Delegates will be held in the second or third week in November; and (3) Our AMA supports scheduling more meetings in Washington, DC, specifically including Interim Meetings of the House on a rotating schedule as frequently as practicable. Our AMA believes, however, that it would not be financially prudent to hold all Interim Meetings in Washington, DC, nor would such a decision be equitable for other regions of the country.	Retain; remains relevant.
H-140.840	Filming Patients for News or Entertainment	American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique)?do not substitute for the need to obtain consent, as outlined in AMA Ethical Opinion E-5.045, for publication of any material related to the treatment of a patient.	Retain as amended: American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique)~~?~~do not substitute for the need to obtain consent, as outlined in ~~AMA Ethical Opinion E-5.045~~ the AMA Code of Medical Ethics Opinions 3.1.3 and 3.1.4, for publication of any material related to the treatment of a patient

H-140.966	Decisions Near the End of Life	Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management.	Retains; remains relevant.

H-160.999	Statements on the Medical Profession	Whether definitely stated or not, it is the position of the AMA that all conditions or principles adopted by the Association concerning the position of the medical profession, in any form of medical practice, are set forth primarily in order to maintain such standards as are essential to the maintenance of the best medical care and the protection of the health of all members of the community.	Retain; remains relevant.
H-175.993	Fraudulent Health Practices	The AMA favors providing information and educational materials to the public and the profession on fraudulent health practices.	Retain; remains relevant.
H-230.966	Physician Appeals Mechanism for Denial of Academic Appointment	Hospital governing boards and hospital medical staffs through their Bylaws must remain responsible for medical staff selection. In situations in which hospital medical staff privileges are granted by contract on the condition of an academic appointment, the physician must be made aware of and agree to the linkage. Under those circumstances when a physician may lose an academic appointment after full and fair due process, no further action is required for revocation of hospital medical staff privileges.	Retain; remains relevant.
H-270.960	Inappropriate Legislative Mandates of eGFR Calculations	Our AMA supports the position that (1) the estimated Glomerular Filtration Rate Calculation (eGFR) calculation, when appropriate and feasible, is a clinically useful calculation that should be promoted in the medical community in a scientific manner as a calculation that does NOT require state legislation or state law that would create an inflexible, politically-based mandate for the practice of medicine that, in general, can be deleterious to patient care; and (2) legislation mandating the eGFR calculation improperly and detrimentally prescribes medical decision-making to the extent that it deprives a physician of the ability to make appropriate, patient-specific clinical judgments regarding the performance of the calculation.	Retain; remains relevant.

H-275.990	Clinical Diagnostic Electromyography	1. Clinical diagnostic electromyographic examinations--involving the selection of the muscles to be studied, modifying the examination as the data unfold, inserting the needle electrodes, recording of and interpreting the data thereby obtained, describing the findings, and the rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data and the electromyographic findings--is the practice of medicine and should be performed only by a fully licensed physician qualified by reason of education, training, and experience in these procedures. 2 Non-physician health care professionals should not expand their scope of practice to include performing needle electromyography. 3. Physicians should not prepare reports and submit claims on needle electromyographic studies that they did not perform or personally supervise. 4. State boards of medical examiners should investigate and take appropriate action whenever cases involving the performance of clinical electromyographic examinations by unqualified persons contrary to the state medical practice acts are brought to their attention.	Retain; remains relevant.
H-370.964	Surrogate Consent for Living Organ Donation	Our AMA opposes the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.	Retain; remains relevant.
H-450.928	Physician Decision Making	Our AMA advocates that treating and attending physicians, regardless of employment status, must maintain overall leadership in decisions affecting the health care received by patients in order to ensure quality of the care given to patients.	Retain; remains relevant.
H-450.990	Physician Information for Credentialing	Our AMA: (1) affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body; and (2) believes that legal immunity for submitting or sharing truthful and accurate information on quality care should be provided to physicians by appropriate legislation.	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-26)

Introduced by: American College of Medical Genetics and Genomics, Medical Student Section

Subject: Ethical Guidance on Postmortem Sample Collection for Genetic Testing

Referred to: Reference Committee on Ethics and Bylaws

Whereas, postmortem genetic testing (PMGT), or molecular autopsy, of blood and/or fresh tissue is an increasingly recognized tool for identifying genetic causes in cases of sudden unexplained death[1,2,7,14]; and

Whereas, PMGT is clinically useful in identifying pathogenic variants and determining familial risk for conditions such as thoracic aortic aneurysm and dissection, inherited arrhythmogenic syndromes (such as cardiomyopathies and channelopathies), and sudden infant death syndrome or sudden unexplained death in childhood[2,12,13]; and

Whereas, PMGT allows for targeted cascade testing of relatives to identify potential carriers, implement preventative measures and surveillance (such as lifestyle modifications and regular imaging), and provide families with psychological benefits and closure following sudden unexplained deathD[1,3-6]; and

Whereas, leading specialty societies including the American College of Medical Genetics and Genomics, the Asia Pacific Heart Rhythm Society, Heart Rhythm Society, European Heart Rhythm Society, Latin American Heart Rhythm Society, the American Heart Association, and the National Association of Medical Examiners, recommend postmortem collection and storage of blood and/or tissue for PMGT in cases of sudden unexplained death, however more guidance on informed consent, privacy, and storage would be helpful for healthcare professionals, patients, and families [4,7,8,9,11,15,16]; and

Whereas, our American Medical Association (AMA) Code of Ethics has established Opinion 4.1.1 (“Genetic Testing & Counseling”), Opinion 3.2.2 (“Confidentiality Postmortem”), and Opinion 4.1.4 (“Forensic Genetics”), which collectively emphasize physicians’ ethical responsibilities to protect the genetic information of patients and their biological relatives while utilizing genetic testing to help diagnose and predict future health risks, but there is no clear statement on the ethics of collecting, storing, and sharing genetic information after death[10]; therefore be it

RESOLVED, that our American Medical Association study the ethical responsibility of physicians in the collection and storage of postmortem biological samples for genetic testing and research when clinically indicated and aligned with existing specialty guidelines. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/3/26

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RELEVANT AMA POLICY

4.1.1 Genetic Testing & Counseling

Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others.

Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient's care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological implications for the individual's biological relatives; (iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and (iv) that the physician will be available to assist in

communicating with relatives. (d) Obtain the individual's informed consent for the specific test or tests to be performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information. [Issued: 2016]

H-480.944 Improving Genetic Testing and Counseling Services
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. [Res. 913, I-16]

H-185.919 Payment and Coverage for Genetic/Genomic Precision Medicine
Our AMA encourages public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: (a) Promote transparency and clarity; (b) Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies; (c) Describe the evidence being considered and methods for updating the evidence; (d) Provide opportunities for comment and review as well as meaningful reconsiderations; and (e) Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival. Our AMA encourages coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage. Our AMA will work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact. Our AMA encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services. Our AMA supports continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine. [Joint CMS / CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 06, A-18 Reaffirmed: CMS Rep. 06, A-19]

H-85.954 Importance of Autopsies
Our AMA: (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: CCB/CLRPD Rep. 01, A-24]

4.1.2 Genetic Testing for Reproductive Decision Making
Genetic testing can provide information to help prospective parents make informed decisions about childbearing. Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse ancestries becomes more common and tests for more conditions become more accurate and less costly, the relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians may ethically provide genetic testing to inform reproductive decision making when the patient requests, but may also wish to offer broad screening to all persons who are considering having a child. Physicians who provide reproductive health care that includes genetic testing should:(c) Obtain the individual's informed consent to the specific test or tests to be performed. Physicians should ascertain whether the person wishes to be informed about incidental findings.(d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors relevant to a decision about childbearing.(e) Respect an

individual's decision to terminate or continue a pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. [Issued 2016]

D-460.996 Medical Genetics
Our AMA will join with the American College of Medical Genetics and other professional and lay organizations to: (1) Publicize the resources and services offered by medical genetics professionals to other medical specialties; and (2) advocate for federal funding specifically targeted to the development and stable support of a clinical genetics infrastructure commensurate with the application of new genetic knowledge to the prevention and treatment of human disease. [Res. 527, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-26)

Introduced by: Florida, the American Academy of Emergency Medicine

Subject: Physician Workload and Scheduling

Referred to: Reference Committee on Ethics and Bylaws

Whereas, excessive patient volumes and overly demanding scheduling requirements can undermine patient safety, contribute to clinician burnout, and increase the risk of medical errors, with evidence demonstrating a significant association between physician burnout and self-reported medical errors[1]; and

Whereas, high workload, time pressure, and inefficient practice environments are well-established drivers of physician burnout and are associated with decreased quality of care and adverse patient outcomes[2,3,4]; and

Whereas, physicians face substantial cumulative workload beyond direct patient care, including documentation and administrative tasks, which further compress time available for safe and thorough patient care[5,6]; and

Whereas, workload, fatigue, and time pressure are recognized contributors to medical error and patient safety events[7]; and

Whereas, our AMA Code of Medical Ethics Opinion 1.1.6, *Quality*, affirms that physicians have an ethical obligation to provide safe, effective, and high-quality care, which may be compromised under conditions of excessive workload; and

Whereas, our AMA Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships*, requires physicians to place patient welfare above external influences, including administrative or financial pressures that may drive unsafe scheduling practices; and

Whereas, our AMA Code of Medical Ethics Opinion 9.3.1, Physician Health and Wellness, states that when physician health or wellness is compromised, the safety and effectiveness of patient care may also be compromised; and

Whereas, our AMA's policy and advocacy efforts on physician well-being support reducing system-level drivers of burnout and promoting flexibility and autonomy in practice conditions; therefore be it

RESOLVED, that our American Medical Association adopt policy affirming that physicians have the professional right and authority to decline, modify, or limit patient volume expectations, scheduling mandates, and staffing conditions that compromise patient safety or their ability to provide safe, thorough, and patient-centered care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for and support state and federal legislation or regulation that ensures local practicing physicians direct and control the development and implementation

of patient scheduling protocols, workload standards, patient panel limits, and clinical staffing models within their practices and health systems, based on clinical complexity, time required for direct and indirect care, and safe practice standards rather than productivity or revenue targets. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

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RELEVANT AMA POLICY

AMA Code of Medical Ethics Opinion 1.1.6 – Quality
As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.
While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

a. Keeping current with best care practices and maintaining professional competence.
b. Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
c. Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.
d. Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
e. Demonstrating commitment to develop, implement, and disseminate appropriate, well- defined quality and performance improvement measures in their daily practice.
f. Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

AMA Code of Medical Ethics Opinion 1.1.1 – Patient-Physician Relationships
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilities to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical

judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship commences when a physician begins to serve a patient's medical needs. The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician, in today's complex health care system, such relationships often involve multiple members of a care team, patient family members, and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.

AMA Code of Medical Ethics Opinion 9.3.1, Physician Health and Wellness
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-26)

Introduced by: American Academy of Ophthalmology

Subject: Artificial Intelligence to Bolster Physician-Led Team-Based Care

Referred to: Reference Committee on Ethics and Bylaws

Whereas, a randomized quality improvement study found that large language model–generated plain language summaries of ophthalmologist encounter notes improved comprehension and clarity for non-ophthalmology clinicians, enhancing interdisciplinary communication; and

Whereas, a cohort study demonstrated that an artificial intelligence deterioration model–enabled intervention, when paired with a collaborative nurse-physician workflow, was associated with an absolute reduction in escalations of care, including rapid response activation, ICU transfer, or cardiopulmonary arrest; and

Whereas, a study of artificial intelligence–enabled collaborative team workflows—one for advance care planning and the other for reducing unplanned escalations of care—found that these workflows reduced misalignment of risk perception and increased coordination between physicians and non-physician team members in performing needed clinical interventions; and

Whereas, physicians are uniquely qualified to lead coordinated care teams, which is the best way to support high-quality care and lower costs; and

Whereas, artificial intelligence is an emerging tool to reinforce the effectiveness of physician-led teams by enhancing collaboration with non-physician clinicians, improving communication, and aligning care around physician judgment; therefore be it

RESOLVED, that our American Medical Association make efforts to educate physicians on evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow integration (Directive to Take Action); and be it further

RESOLVED, that our AMA support the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision-making (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

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RELEVANT AMA POLICY

D-480.952 Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence
Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings.
1. Our AMA advocates that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:
a. establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
b. implement relevant security measures and privacy protections;
c. provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and
d. implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts. [Res. 507, A-25]

D-480.954 Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
2. Our AMA will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight. [CSAPH Rep. 08, A-25]

H-310.898 Increasing Education on Physician-Led Care and Advocacy in Residency Training
Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.
Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations. [Res. 309, A-25]

G-615.998 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
Our American Medical Association will establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition this task force to a new council and report back A-25 on this transition.
Our AMA Task Force on AI, Digital Health, and Informatics will work toward an informed recommendation on the long-term model for HOD input with a report back at the 2026 Interim meeting. [Res. 606, A-24; Appended: BOT Rep. 24-25]

H-160.912 The Structure and Function of Interprofessional Health Care Teams
Our American Medical Association defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
1. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that they are trained to perform.
2. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
3. Our AMA adopts the following principles to guide physician leaders of health care teams:
a. focus the team on patient and family-centered care.
b. make clear the team's mission, vision and values.
c. direct and/or engage in collaboration with team members on patient care.
d. be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
e. foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
f. encourage adherence to best practice protocols that team members are expected to follow.
g. manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
h. promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. review measures of 'population health' periodically when the team is responsible for the care of a defined group.
4. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
5. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members. [Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, 1-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17; Reaffirmed: CMS Rep. 1, 1-23; Modified: Speakers Rep. 02, I-24]

H-295.857 Augmented Intelligence in Medical Education
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new

training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications. [BOT Rep.41, A-18; Reaffirmed: CMS Rep.97, A-24; Reaffirmed: CSAPH Rep. 08, A-25]

H-390.843 Physician-Led, Single and Multi-Specialty, Organized Group Practice Models
1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care.
2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost. [Sub. Res. 212, I-13; Appended: BOT Rep. 21, A-15; Reaffirmed: CMS Rep. 01, A-25]

H-480.940 Augmented Intelligence in Health Care
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
5. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
6. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. [BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25]

H-480-931 Augmented Intelligence Development, Deployment, and Use in Health Care
1. General Governance
a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance

policies should include interdepartmental and interagency collaboration.
c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
i. AI disclosure should align and meet ethical standards or norms.
ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.
ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
iv. Intended population and intended practice setting.
v. Clear description of any limitations or risks for use, including possible disparate impact.
vi. Description of how impacted populations were engaged during the AI lifecycle.
vii. Detailed information regarding data used to train the model:
1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.
viii. Validation Data/Information and evidence of:
1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.
x. information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]
4. Generative Augmented Intelligence
a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v. Data privacy.
vi. Cybersecurity.
vii. Physician liability associated with the use of generative AI tools.
c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at

(3)(d)]
d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
a. Entity Responsibility:
i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
b. User Education:
i. Users should be provided with training specifically on generative AI. Education should address:
1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.
[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]
7. Augmented Intelligence Cybersecurity
a. AI systems must have strong protections against input manipulation and malicious attacks.
b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be

monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws. [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep.08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-26)

Introduced by: Women Physicians Section

Subject: Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities

Referred to: Reference Committee on Ethics and Bylaws

Whereas, individuals with intellectual and developmental disabilities (IDD) represent a diverse population with varying levels of decision-making capacity, and many retain meaningful ability to participate in reproductive healthcare decisions;[1–3] and

Whereas, decision-making capacity is task-specific, meaning individuals with IDD may have the ability to provide informed consent for certain reproductive decisions even if they require support or guardianship for other aspects of daily living;[4–6] and

Whereas, supported decision-making frameworks enable individuals with IDD to make their own healthcare choices with assistance in understanding information, communicating preferences, and evaluating options, without transferring decision-making authority;[4–6] and

Whereas, historical abuses—including forced sterilization and coercive contraception—have disproportionately targeted people with disabilities, particularly women, people of color, and LGBTQ+ individuals, resulting in long-standing mistrust and ongoing reproductive injustice;[7–10] and

Whereas, national clinical organizations, including the American College of Obstetricians and Gynecologists, have identified patients with disabilities as a population facing persistent and significant barriers to reproductive healthcare—including inaccessible clinical environments, communication challenges, and legal complexities surrounding permanent contraception—and have issued dedicated guidance to address these inequities, underscoring the urgency of strengthening protections for autonomy and valid consent for individuals with intellectual and developmental disabilities;[11] and

Whereas, forced sterilization of people with disabilities remains legally permissible in 31 states, as acknowledged in recent federal resolutions, and several states have recently debated legislation either restricting or expanding guardians' authority to consent to sterilization or long-acting contraception on behalf of individuals with IDD, including New York Senate Bill S3357 (2025–2026);[10,15–17] and

Whereas, multiple states have recently enacted or introduced supported decision-making (SDM) laws that recognize the right of people with disabilities to make their own healthcare decisions with assistance, with at least 39 states and the District of Columbia adopting SDM statutes or court-recognized frameworks;[4–6,18] and

Whereas, ethical contraceptive care requires maximizing patient agency, providing accessible communication, and avoiding paternalistic or convenience-based decision-making by caregivers or clinicians;[4–6,12–14] therefore be it

RESOLVED, that our American Medical Association affirm that individuals with intellectual and developmental disabilities (IDD) have the right to meaningful participation in all reproductive healthcare decisions to the maximum extent of their abilities (New HOD Policy); and be it further

RESOLVED, that our AMA amend H-90.968 “Medical Care of Persons with Disabilities” by addition to read as follows:

1. Our American Medical Association encourages:
    a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.
    b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.
    c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.
    d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
    e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.
    f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
    g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks:
    a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.
    b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:
    a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.
    b. An individual’s medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that
    a. incorporates critical disability studies.
    b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:
    a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.
    b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.
    c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.
    d. <u>Clinicians to obtain direct, task-specific informed consent from individuals with IDD whenever they demonstrate capacity for the decision at hand</u> and, when <u>legally required, the consent of a guardian or other authorized decision-maker.</u>

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA support clinician education on disability-competent reproductive care, including accessible communication strategies, historical context, and best practices for ethical contraceptive counseling for individuals with IDD. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-90.96 Medical Care of Persons with Disabilities

1. Our American Medical Association encourages:
    a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.
    b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.
    c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.
    d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
    e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.
    f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
    g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks:
    a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.

   b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:
   a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.
   b. An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.
4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that
   a. incorporates critical disability studies.
   b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:
   a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.
   b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.
   c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

[CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22]

H-90.967 Support for Persons with Intellectual Disabilities

Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

[Res. 01, A-16]

H-65.965 Support of Human Rights and Freedom

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.

4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

[CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22; Modified: Speaker Rep. 02, I-24]

D-330.900 Support for Medicare Coverage of Contraceptive Methods

Our AMA will work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved contraceptive methods for contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of eligibility pathway (age or disability).

[Res. 117, A-19]

H-510.984 Infertility Benefits for Veterans

1. Our American Medical Association supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
6. Our AMA will work with interested organizations to encourage TRICARE to cover:
    1. Fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE.
    2. Gamete preservation for active-duty military personnel and activated reservist military personnel.
7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of service-connected disability, marital status, gender or sexual orientation.

[CMS Rep. 01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22; Appended: Res. 801, I-22; Reaffirmed: Res. 005, I-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-26)

Introduced by: Indiana

Subject: Impersonation of a Physician

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the impersonation of a licensed physician poses a serious threat to public health and patient safety, leading to potential misdiagnoses, improper treatments, and fraudulent medical practices; and

Whereas, there have been documented cases nationwide of individuals fraudulently representing themselves as physicians, leading to physical, emotional, and financial harm to patients; and

Whereas, organizations in our state offering care to pregnant people often are mistaken as medical facilities staffed by medical providers; and

Whereas, the unauthorized practice of medicine undermines the integrity of the medical profession and erodes public trust in legitimate healthcare providers; and

Whereas, Indiana Code § 35-44.1-2-6 currently addresses impersonation of public servants, but does not explicitly include licensed physicians within its scope unless they are acting in a governmental capacity; and

Whereas, Indiana Code § 25-22.5-8.2 currently makes it a felony to unlawfully practice medicine or osteopathic medicine; and

Whereas, existing state and federal penalties for impersonating a physician may not adequately deter such fraudulent behavior, and stronger legal repercussions are necessary to prevent and penalize such offenses; and

Whereas, many states have enacted strict laws to address medical impersonation, and Indiana should align its policies with the most stringent protections for public safety; therefore be it

RESOLVED, that our American Medical Association recognizes physician impersonation as a significant threat to public health and patient safety; supports the creation and enforcement of state laws prohibiting such conduct; encourages clear public reporting mechanisms through state medical boards; and promotes improved coordination among regulatory bodies to prevent and address impersonation of licensed physicians. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-26)

Introduced by: Indiana

Subject: Investigating Moral Injury Related to Organ Procurement Practices

Referred to: Reference Committee on Ethics and Bylaws

Whereas, Indiana is primarily served by the Indiana Donor Network, an organ procurement organization (OPO) designated as Tier 3 by the Centers for Medicare and Medicaid Services (CMS) in 2023, reflecting performance below national benchmarks for organ recovery and utilization[1]; and

Whereas, Indiana physicians have raised concerns regarding OPO conduct, including aggressive donation approaches, inappropriate timing of family interactions, and lapses in transparency; practices that may compromise the therapeutic alliance with patients and families at the end of life; and

Whereas, significant incidents have further eroded physician confidence in the OPO system, including a 2016 probation by the Organ Procurement and Transplantation Network (OPTN) for documentation and quality deficiencies[2], a 2020 incident involving the accidental disposal of two viable kidneys[3], and a 2024 investigative report revealing misuse of OPO-owned aircraft for non-clinical travel[4]; and

Whereas, physicians in Indiana have experienced ethical distress and professional conflict during organ procurement, including inappropriate pressure to withdraw care to align with transplant timelines and the need to manage family trauma resulting from OPO missteps. These circumstances result in emotional strain and professional dissonance consistent with the clinical definition of moral injury; and

Whereas, moral injury, distinct from burnout, is defined as psychological harm resulting from being forced to act against one's ethical or professional values[5, 6]; and

Whereas, current American Medical Association (AMA) policy does not address physician moral injury arising from organ procurement practices, nor are there standardized institutional mechanisms for recognizing or addressing these harms[7]; therefore be it

RESOLVED, that our American Medical Association study the national scope and causes of physician moral injury related to organ procurement, and to develop ethical guidelines and best practices that prioritize patient dignity and physician integrity in organ procurement practices. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. [BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18]

Endorsement of the Uniform Anatomical Gift Act (2006) H-370.968
Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA. [BOT Action in response to referred for decision Res. 901, I-06; Reaffirmed: BOT Rep. 06, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-26)

Introduced by: Indiana

Subject: Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software

Referred to: Reference Committee on Ethics and Bylaws

Whereas, artificial intelligence (AI)-based scribe software is rapidly being integrated into clinical workflows with the goal of enhancing documentation efficiency and reducing physician administrative burden; and

Whereas, such technologies often rely on real-time or asynchronous data capture, which may include sensitive conversations between physicians and patients and raise concerns about the privacy of both parties; and

Whereas, current regulatory frameworks, including HIPAA, may not be sufficient enough to cover the legality of third-party AI scribe systems; and

Whereas, the storage, processing, and transmission of physician speech data by AI vendors may lack sufficient transparency, oversight, and limits on duration and secondary use, posing potential risks to personal and professional autonomy, workplace surveillance, and unauthorized profiling; and

Whereas, Indiana physicians have the right to practice in an environment that protects their privacy and ensures informed consent regarding the collection and usage of their data by AI systems; and

Whereas, the Indiana State Medical Association (ISMA) supports responsible innovation in medical technology that aligns with the ethical principles of autonomy, transparency, data minimization, and accountability; therefore be it

RESOLVED, that our American Medical Association pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy by mandating informed consent, opt-in for secondary use, data minimization, and federal vendor accountability. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

Study of Minimum Competencies and Scope of Medical Scribe Utilization D-478.967
Our American Medical Association will monitor the medical scribe industry periodically to identify important trends and will continue to review and promote strategies that help improve physician practice workflow. [BOT Rep. 20, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-26)

Introduced by: Senior Physicians Section

Subject: Senior Physicians Improving Patient Access

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the SPS Governing Council seeks to advance initiatives that benefit patients, practicing physicians, and semi-retired or retired physicians alike; and

Whereas, the U.S. healthcare system faces persistent challenges, including physician workforce shortages that increase workloads and affect care delivery; and

Whereas, patients as well are experiencing excessive wait times for new physician appointments, and for obtaining expedited clinic visits for recently discharged patients; and

Whereas, many communities across the nation include a substantial number of semi-retired and retired physicians who can offer valuable expertise, experience and flexibility; and

Whereas, these seasoned physicians are well-positioned to provide initial consultations, to help ensure necessary previsit laboratory testing before patients see their primary physician, and help to facilitate prompt follow-up visits after recently hospital discharges through in-person or telehealth visits; and

Whereas, in some communities, programs exist that enable timely follow-up after hospital discharge, and some that introduce a patient to a new practice before seeing a new primary care physician, by involving late-career physicians (both semi-retired and retired)[1,2]; therefore be it

RESOLVED, that our American Medical Association look for innovative approaches to help alleviate the workload of actively practicing physicians while at the same time providing late-career physicians with opportunities for fulfilling part-time work (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association study programs [such as WIN CUBED[1]] that enable timely follow-up after hospital discharge or ambulatory services by providing meaningful part-time work opportunities to late-career physicians (both semi-retired and retired). (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/16/26

REFERENCES

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RELEVANT AMA POLICY

D-160.905 Improvements to Patient Flow in the U.S. Healthcare System
Our American Medical Association will work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system.
[Res. 709, A-24]

11.1.3 Allocating Limited Health Care Resources
Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:

(a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.
(b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).
(c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).
(d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.

AMA Principles of Medical Ethics: I,VII

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-26)

Introduced by: Resident and Fellow Section

Subject: Preserving Access to Care for Undocumented Individuals

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the American Medical Association (AMA) recognizes migrant status as a determinant of health (D-60.966, H-65.938), and opposes measures that ostracize migrants from healthcare services (D-440.927) or positions of employment (H-65.932); and

Whereas, our AMA opposes proposed rules, regulations, or policies that would deter immigrants from accessing healthcare (D-440.927) and opposes the criminalization of healthcare providers and systems who provide services to undocumented individuals (H-440.876); and

Whereas, the One Big Beautiful Bill (OBBB) imposed sweeping Medicaid changes including reduced Medicaid reimbursement through the Federal Medical Assistance Percentages (FMAPs), and imposed penalties for states extending Medicaid coverage to undocumented individuals;[1,2] and

Whereas, several states including Illinois, California, and Minnesota have rolled back, frozen enrollment, or ended coverage for undocumented individuals in response to fiscal pressures exacerbated by OBBB[3,4,5,6]; and

Whereas, Massachusetts, one of the only states with a primarily state-funded safety net program for undocumented immigrants has expanded funding despite national trends to the opposite[2]; and

Whereas, in 2019, approximately 20% of all uninsured individuals were undocumented with approximately 50% of all undocumented individuals lacking insurance[7]; therefore be it

RESOLVED, that our American Medical Association study the impacts of the One Big Beautiful Bill on Medicaid-expansion and health safety net programs and insurance coverage for undocumented people with recommendations to improve healthcare coverage for undocumented individuals with a report back. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/21/26

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RELEVANT AMA POLICY

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA opposes; a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; b. any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status; c. proof of citizenship as a condition of providing health care; and d. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our American Medical Association 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.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
    a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
    d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
    e. The public option is financially self-sustaining and has uniform solvency requirements.
    f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
    g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
    a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
    b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
    c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
    d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
    e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
    g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
    h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
    a. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
    b. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
    c. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
    d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans.

[CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24]

Reducing the Harmful Impacts of Immigration Status on Health H-65.932

1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
3. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
4. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.

5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

Guiding Principles for the Healthcare of Migrants H-65.938

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
    a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
    b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
    c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
    d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
    e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems. [Res. 016, A-24]

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. [Res. 016, A-17]

Immigration Status in Medicaid and CHIP D-440.911

Our American Medical Association advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. [Res. 210, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-26)

Introduced by: Resident and Fellow Section

Subject: Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

Referred to: Reference Committee on Ethics and Bylaws

Whereas, fatigue and sleep deprivation among intern, resident, and fellow physicians are well-documented contributors to motor vehicle accidents, threatening not only physician safety but also patient and public safety[1,2]; and

Whereas, extended work hours and overnight shifts remain common in graduate medical education, leaving trainee physicians chronically vulnerable to fatigue-related harm when traveling to and from clinical sites[3]; and

Whereas, the literature shows that driving while fatigued after an overnight or extended shift impairs sustained attention and vigilance to a degree comparable to alcohol intoxication, substantially increasing the risk of motor vehicle accidents[4-5]; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) recognizes physician well-being as a critical institutional responsibility and mandates strategies to mitigate fatigue[6]; and

Whereas, ACGME policy 6.16 explicitly requires that "the program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home"[7]; and

Whereas, implementation of this policy remains inconsistent across residency and fellowship programs nationwide, leaving many trainee physicians (who often have limited financial resources) without access to safe, reliable, and funded transportation when fatigued; and

Whereas, a study of a university-affiliated general surgery residency program demonstrated that a low-cost rideshare reimbursement initiative significantly reduced residents' self-reported frequency of falling asleep or nearly falling asleep while driving, illustrating a clear, evidence-based intervention[8]; and

Whereas, some residency and fellowship programs, such as those at the University of California, Los Angeles, provide fully-funded rideshare access for travel to and from the hospital surrounding shifts[9]; and

Whereas, such resources are neither consistently available nor equitably funded nationwide, creating gaps in the safety of trainee physicians and underscoring the need for coordinated action at the national level; therefore be it

RESOLVED, that our American Medical Association supports the provision of fully-funded transportation options (including, but not limited to, rideshares and taxis) for intern, resident, and

fellow physicians after extended or overnight shifts as a core fatigue mitigation strategy, with costs not borne by trainees. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
With regard to benefits, residents and fellows must be fully informed of and should receive: Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues. Confidential access to mental health and substance abuse services. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks. Leave in compliance with the Family and Medical Leave Act. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24; Modified: Res. 304, I-24]

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to

include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
    a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
    b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
    c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
    d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
    a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
    b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
    c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
    d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
    a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
    b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
    c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
    d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
    f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.

g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i. Scheduled time providing patient care services of limited or no educational value should be minimized.
j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

[CME Rep. 5, A-14Modified: CME Rep. 06, I-18Reaffirmation: A-22]

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958

1. Our American Medical Association recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.
2. Our AMA recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
3. Our AMA recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
4. Our AMA encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.

5. Our AMA urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
6. Our AMA recommends that physicians:
    a. become knowledgeable about the diagnosis and management of sleep-related disorders.
    b. investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories.
    c. inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries.
    d. advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery.
    e. inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries.
    f. become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
7. Our AMA encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
8. Our AMA recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
9. Our AMA reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

[CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19; Reaffirmation: A-22]

Reference Committee A

Report(s) of the Board of Trustees

23 Liberalized Remorse Period for Medicare Advantage Plan Insureds

Report(s) of the Council on Medical Service

03 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
05 Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
08 Rural Health Transformation Program Update & Workforce Challenges

Resolutions

101 Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01"Morbid (Severe) Obesity Due to Excess Calories"
102 Study for EMTALA Relief in Psychiatric Facilities
103 Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
104 Improving Choice, Competition, and Affordability in the ACA Marketplaces
105 Oppose Medicare Advantage Auto Enrollment
106 Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
107 Oversight of Medicare Advantage Plan
108 Ensuring Physician Input in the Development of CMMI Models
109 Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy
110 Medicaid Coverage for Incarcerated Individuals
111 Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia
112 Ensuring Coverage and Access to Adult Strabismus Surgery
113 Health Insurance Coverage of Hearing Devices and Related Services
114 Opposing Alternative Funding Programs
115 Patient Continuity Protections During Payer, PBM Changes
116 Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs
117 Universal Out of Network Benefits
118 Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

REPORT OF THE BOARD OF TRUSTEES

BOT Report 23-A-26

Subject: Liberalized Remorse Period for Medicare Advantage Plan Insureds

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee A

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

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

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

BACKGROUND

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

In addition to these two standard enrollment periods, there are Special Enrollment Periods for which beneficiaries can become eligible due to many reasons. These include whether the beneficiary moves or their circumstances change, such as admission to or discharge from a nursing facility. They also include coverage changes such as losing Medicaid eligibility or being offered coverage from a union or employer, as well as plan changes such as the plan ending its Medicare contract or CMS ending its contract with the plan or sanctioning the plan. Other factors that make beneficiaries eligible for a Special Enrollment Period

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are if they are in an MA plan with a relatively low star rating and/or want to enroll in a five-star plan, as well as if their choice was based on bad information. Other important reasons that beneficiaries can change their Medicare coverage are if there is a significant change in the plan's provider network or if they chose their MA plan based on incorrect information about the network. For example, CMS recently adopted an AMA recommendation that MA plans include their physician directories on the Medicare Plan Finder. The agency then determined that beneficiaries who choose a plan based on incorrect information in the Medicare Plan Finder about their physician being in-network are eligible for a Special Enrollment Period.

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

AMA POLICY

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

DISCUSSION

Beneficiaries do not receive clear and objective information about the Medicare program and how to choose their Medicare coverage, either when they initially become eligible for the program or during the Medicare Annual Enrollment Period. They may choose to enroll in an MA plan without knowing what it means to have a network, whether their physician(s) is in the plan's network, or whether the network will be able to offer the types of care they may need at a location and cost that is accessible to them. Many beneficiaries who choose MA believe they will have lower out-of-pocket costs in MA. Although this is possible as MA plans have out-of-pocket spending limits that traditional Medicare does not, the limits can be as high as $9,250 for in-network services and $13,900 for combined in- and out-of-network services. Beneficiaries with a Medigap supplemental policy may not understand that they cannot use their Medigap coverage for copayments once they enroll in MA, nor that the MA cost-sharing for services like chemotherapy could be just as expensive in MA as in regular Medicare Part B. Most tests, referrals, admissions, procedures, and therapies are available in traditional Medicare without prior authorization, but prior authorization requirements are pervasive in MA. (There is prior authorization for many medications whether patients are in MA or in traditional Medicare with a standalone Part D prescription drug plan.)

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

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

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

RECOMMENDATIONS

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

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

Fiscal note: Less than $500

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates referred Resolution 113-A-25, which asks that the American Medical Association (AMA) support efforts to expand telepharmacy, advocate for equitable pharmacy reimbursement, and study the impact of preferred pharmacy networks with the goal of mitigating access issues for patients in pharmacy deserts.

The Council on Medical Service reviewed information on the current state of pharmacies across the United States and the elements involved in their ability to succeed. Currently, pharmacies are facing a closure crisis, leading to many communities being deemed "pharmacy deserts," or areas in which residents do not have adequate access to a pharmacy. Pharmacies face a number of issues in remaining financially viable. Low reimbursement rates from payers are often driven by pharmacy benefit manager (PBM) negotiations resulting in rates that do not cover the full acquisition and operating costs associated with a drug. Further, many PBMs are vertically integrated with payers and/or large chain pharmacies leading to a highly concentrated market and, often, resulting in anticompetitive practices or PBMs excluding small/community pharmacies from preferred pharmacy networks. The Council reviewed the literature and considered a variety of information on a number of potential solutions to support pharmacies and reduce pharmacy deserts. First, the Council reviewed alternative dispensing methods, such as telepharmacy, remote dispensing, and mail order dispensing. Both telepharmacy and remote dispensing allow patients who cannot access a full-service pharmacy to access pharmacist services via the internet. Further, mail order pharmacy services allow patients, especially those with managed chronic conditions, to receive a convenient supply of medication delivered to their home. Although these types of prescription dispensing have been shown to be beneficial to patients and pharmacies, challenges remain when there is not reliable access to broadband, patients lack safe mail delivery methods, and the prescription is not shelf-stable or is needed urgently. Second, the Council explored legislative and regulatory solutions, including PBM regulation and boosted reimbursement rates. These types of regulations have shown promise, especially at the state level, in ensuring pharmacies receive reimbursement adequate for operations and limiting untoward PBM practices. Finally, the Council reviewed federal, state and non-governmental incentive-based solutions. Similar to programs designed to attract physicians to underserved areas, these programs are designed to make operating a pharmacy in an underserved area more possible and, in some cases, advantageous for pharmacists.

Based on its review of the issue, the Council recommends the adoption of new AMA policy that supports efforts to ensure that pharmacy reimbursement rates are adequate to cover the actual costs related to obtaining and dispensing medications. The Council also recommends policy that supports the establishment of a minimum preferred pharmacy network adequacy standard and recognizes and encourages payer coverage of telepharmacy and remote dispensing when specific criteria are met. Furthermore, the Council recommends new policy that supports payer and PBM practices that promote fair market competition, patient choice, and support the financial viability of independent and community pharmacies. In addition to new policies, the Council recommends the reaffirmation of Policy H-120.989, which outlines appropriate mail order pharmacy practices and recognizes it as a legitimate drug dispensing method, and Policy D-110.987, which outlines advocacy efforts related to PBM regulation towards increased transparency.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-26

Subject: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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

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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 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] 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 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 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]

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.

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.

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. (New HOD Policy)

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, when possible, independent pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)

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. (New HOD Policy)

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. (New HOD 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. (New HOD Policy)

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. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation. (Reaffirm HOD Policy)

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)

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. (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 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)

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)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-26

Subject: Inclusion of Discounted Prescription Medication in Patient Cost-Sharing

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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.

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.

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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 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 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 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 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. (New HOD Policy)

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.
   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)

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)

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Rural Health Transformation Program Update & Workforce Challenges

EXECUTIVE SUMMARY

As a follow-up to CMS Report 3-I-25, Payment Models to Sustain Rural Hospitals, the Council initiated this report to provide an update on the Rural Health Transformation (RHT) program and discuss workforce challenges faced by physicians in rural settings.

In an attempt to address funding concerns in rural settings resulting from the disproportional impact of cuts to Medicare, Medicaid, and the Affordable Care Act in H.R. 1, a one-time $50 billion RHT program was created. Three-quarters of funding will be distributed across five years, based on state applications, Centers for Medicare & Medicaid Services (CMS)-evaluated state need, and CMS-scoring of state initiatives and policies. The other one-quarter of funding will be distributed based on state policy and application alignment with the administration's stated goals and agenda. While the RHT program is a significant investment in rural health, it remains to be seen if the program is able to not only make up for deficits but support improvements for rural Americans. In addition to reviewing information on the RHT program, the Council reviewed information related to workforce challenges that are faced by rural physicians. Rural communities face significant challenges in both attracting and retaining physicians. Issues such as a lack of infrastructure, complicated certification/training opportunities, and physician burnout significantly increase the challenges faced in rural communities. Further, international medical graduates and rural-born or rural-trained medical students have been shown to be more likely to practice in rural settings, and thus programs to support and incentivize these physicians towards rural settings could bolster the rural physician workforce.

Based on its review of the RHT program and rural workforce issues, the Council recommends the adoption of four new policies. First, policy to closely monitor and educate physicians and legislators regarding the RHT program and similar initiatives. Second, policy to support the development and funding of programs designed to both implement and expand telehealth in rural settings. Third, policy to support efforts to ensure that physicians practicing in rural settings have access to continuing medical education and professional development requirements. Fourth, policy to support the expansion of programs designed to support or define physician shortage areas to include specialties necessary for the functioning of a rural medical practice or hospital. Finally, the Council recommends the reaffirmations of Policy H-465.994, which outlines efforts to support rural health solutions, Policy D-200.980, which details strategies to bolster the physician workforce in underserved areas, and Policy H-465.988, which focuses on supporting the physician workforce through education and practice-based solutions.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-26

Subject: Rural Health Transformation Program Update & Workforce Challenges

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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.

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

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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 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 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]

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 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 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.

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.

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. (New HOD Policy)

2. That our AMA support the development of funding avenues designated to support costs associated with telehealth in rural hospitals and medical practices. (New HOD Policy)

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. (New HOD Policy)

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. (New HOD Policy)

5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and innovate solutions to improve rural health. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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.
    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.
   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.
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.
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)

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-26)

Introduced by: Washington

Subject: Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”

Referred to: Reference Committee A

Whereas, weight bias is prevalent in health care settings, particularly for patients with obesity, and has been well-documented to be associated with an increased stress response, increased health care avoidance, and poorer health outcomes for patients[1]; and

Whereas, person-centered care is a core tenet of primary care specifically and health care generally; and

Whereas, the ICD-10 code E66.01 “morbid (severe) obesity due to excess calories” has been perceived by patients to be stigmatizing and perpetuates biased language in medicine; and

Whereas, less stigmatizing language is included in E66.811-E66.813 (obesity, class 1-3); and

Whereas, the ICD-10 code E66.01 is frequently the only code payers use for risk-adjusted payments to physicians; therefore be it

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payors for equivalent, risk-adjusted payment for alternate codes with more patient-centered, neutral, and non-stigmatizing language in place of ICD-10 code E66.01. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 3/13/26

REFERENCES

1. Schwartz MW, Seeley RJ, Zeltser LM, Drewnowski A, Ravussin E, Redman LM, Leibel RL. Obesity Pathogenesis: An Endocrine Society Scientific Statement. Endocr Rev. 2017 Aug 1;38(4):267-296. doi: 10.1210/er.2017-00111. PMID: 28898979; PMCID: PMC5546881.

RELEVANT AMA POLICY

D-65.969 Use of Inclusive Language
Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will amend existing policies to ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments.

Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will identify other types of outdated language in AMA policies and devise a timely mechanism for editorial changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates.

D-70.942 Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
Our American Medical Association will collaborate with the Centers for Disease Control and Prevention and the National Center for Health Statistics ICD-10 Coordination and Maintenance Committee to advocate for the World Health Organization to adopt destigmatizing terminology in ICD-10 and future ICD codes and to eliminate existing stigmatizing diagnostic synonyms.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-26)

Introduced by: Pennsylvania

Subject: Study for EMTALA Relief in Psychiatric Facilities

Referred to: Reference Committee A

Whereas, Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 to ensure public access to emergency medical services regardless of a patient's ability to pay; and

Whereas, EMTALA requires hospitals to provide a medical screening examination to anyone requesting treatment for an emergency medical condition; and

Whereas, if an emergency condition is identified, the hospital must stabilize the patient before transferring or discharging them; and

Whereas, the original EMTALA bill had exempted psychiatric hospital facilities, but various exemptions were inadvertently lost in the legislative process without specific explanation; and

Whereas, EMTALA prevents hospitals from refusing treatment or transferring patients based on their insurance status or ability to pay; and

Whereas, many free-standing psychiatric hospitals are used by local law enforcement for any disruptive person in police custody, or by emergency departments that transfer intoxicated patients; and

Whereas, this unfairly burdens free-standing psychiatric facilities; therefore be it

RESOLVED, that our American Medical Association perform a study to determine whether it would be appropriate to seek EMTALA relief, exemption, or modifications for exclusively psychiatric hospital facilities. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:103
(A-26)

Introduced by: Florida, Oklahoma, Medical Student Section

Subject: Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients

Referred to: Reference Committee A

Whereas, the United States spent an estimated $650 billion on prescription drugs in 2023 after discounts, with approximately one-third of that total—$215 billion—flowing to PBMs, wholesalers, and pharmacies rather than manufacturers, reflecting the substantial financial impact of intermediaries in the drug supply chain[1]; and

Whereas, patients frequently face high out-of-pocket costs for essential medications due to formulary exclusions, prior authorization barriers, and pricing practices driven by PBMs and insurance intermediaries, including the use of high list prices that increase patient cost-sharing even when net prices fall, a dynamic well-documented in analyses of PBM rebate structures[2,3]; and

Whereas, PBM compensation models tied to drug list prices have been shown to incentivize higher list prices and steer patients toward more expensive medications, with research indicating that delinking PBM compensation from list prices could reduce national drug spending by nearly $100 billion annually[1, 4]; and

Whereas, a growing number of Americans—including those without comprehensive insurance—use alternative platforms to obtain FDA-approved medications prescribed by licensed physicians, including coupon-based retail programs for generic and name brand drug, (e.g., GoodRx, Trump Rx), direct-to-consumer pharmacies (e.g., Mark Cuban Cost Plus Drugs), and direct manufacturer-to-patient programs (e.g., Lilly Direct, Pfizer for All), in order to reduce medication costs[5]; and

Whereas, these platforms often provide prices substantially lower than insurance-based retail prices, in part because they bypass PBM-driven markups and rebate structures, and without such platforms many patients would be unable to obtain necessary therapies[6]; and

Whereas, the American Medical Association has long-standing policies supporting access to affordable prescription drugs, reducing financial barriers for patients, and promoting transparency in pharmaceutical pricing[7]; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should match the lowest available bona fide patient price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

REFERENCES

https://schaeffer.usc.edu/research/pbm-delinking-drug-cost-savings/
https://paragoninstitute.org/private-health/pbm-101-what-they-are-and-how-they-affect-drug-prices/
AMA Policies H-110.987, H-110.980, H-125.979
AMA Policies H-125.991, H-125.984
AMA Policies H-125.991, H-125.988
AMA Policies H-110.987, H-125.979, H-125.991
AMA Policies H-110.987, H-125.979, H-125.991

RELEVANT AMA POLICY

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

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.
   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

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.
   Sub. Res. 724, A-14 Appended: Res. 701, A-16 Appended: Alt. Res. 806, I-17 Reaffirmed: CMS Rep. 07, A-18 Reaffirmed: BOT Rep. 20, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: CMS Rep. 2, A-21 Reaffirmed: CMS Rep. 06, A-24

Drug Formularies and Therapeutic Interchange H-125.991

It is the policy of the AMA:

(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and

(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies.
BOT Rep. 45, I-93 Reaffirmed by Sub. Res. 501, A-95 Appended: BOT Rep. 7, I-99 Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00 Reaffirmed: Res. 515, I-00 Reaffirmed: CMS Rep. 8, A-02 Reaffirmed: Res. 533, A-03 Modified: CMS Rep. 6, A-03 Modified: CSA Rep. 2, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 535, A-05 Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05 Reaffirmed: CMS Rep. 2, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmed: CMS Rep. 2, A-10 Reaffirmed: CMS Rep. 01, A-20

Generic Drugs H-125.984
Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.

(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.

(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.

(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.

(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.

(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).

(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.
CSA Rep. 6, A-02 Reaffirmed: CSAPH Rep. 2, A-07 Reaffirmation A-08 Reaffirmation A-09 Reaffirmed in lieu of Res. 525, A-10 Reaffirmed in lieu of Res. 224, I-14 Reaffirmed in lieu of: Res. 922, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Medical Student Section

Subject: Improving Choice, Competition, and Affordability in the ACA Marketplaces

Referred to: Reference Committee A

Whereas, the Affordable Care Act (ACA) established state-based Health Insurance Marketplaces, providing coverage to over 21 million people through regulated exchanges with private insurers, and organizes plans into metal tiers (bronze, silver, gold, platinum) that cover varying proportions of healthcare costs (60%, 70%, 80%, and 90%, respectively)[1-2]; and

Whereas, tax credits that help pay for ACA plan premiums ("premium tax credits") are available to US citizens and lawfully present immigrants who purchase Marketplace coverage with income greater than 100% of the Federal Poverty Level, but are ineligible for public coverage (e.g. Medicaid, TRICARE, CHIP), and are not offered affordable employer-sponsored health insurance[3-5]; and

Whereas, ACA premium tax credits provide substantial savings of $5,534 per year on average to qualifying enrollees[6]; and

Whereas, premium tax credits are calculated by comparing an enrollee's income to the premium of the second-lowest cost silver plan, which acts as a "benchmark plan"; for example, if the benchmark plan has a monthly premium of $1000 but the enrollee should only be paying $250 based on their income, the enrollee provides a premium tax credit of $750 that can be applied to the premium of any plan on the Marketplace[7]; and

Whereas, increasing the benchmark plan to the second-lowest cost gold plan could increase premium tax credits and reduce out-of-pocket costs for most enrollees[8,9]; and

Whereas, the premium tax credit can only be applied to the portion of a plan's premium that covers Essential Health Benefits (EHBs), which are federally-defined health benefits that exclude essential healthcare services like dental benefits, routine eye exams, and certain forms of long-term care[10,11]; and

Whereas, when a patient's premium tax credit exceeds the premium for the selected plan, the difference is lost, leading to reduced financial support for lower-income enrollees selecting cheaper plans[10]; and

Whereas, limiting premium tax credit application to EHBs significantly limits plan choice and competition in the ACA Marketplaces, and artificially limits access to care for benefits that are not considered EHBs[12-15]; and

Whereas, addressing these inefficiencies in the ACA Marketplaces would expand competition and choice while improving affordability for patients, moving the United States closer to universal, equitable health coverage; therefore be it

RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits (New HOD Policy); and be it further

RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

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RELEVANT AMA POLICY

Individual Health Insurance H-165.920
Our AMA will: (3) actively supports the principle of the individual's right to select his/her 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. (4) will identify any further means through which universal coverage and access can be achieved; (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. [BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by

Sub. Res. 125 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-99Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00Reaffirmation 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-03Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07Appended 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-1; 2Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17]

Improving Affordability in the Health Insurance Exchanges H-165.824
1. Our American Medical Association will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (c) support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. 2. Our AMA supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (b) increasing the generosity of premium tax credits. (c) expanding eligibility for cost-sharing reductions. (d) increasing the size of cost-sharing reductions. [CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-26)

Introduced by: New York

Subject: Oppose Medicare Advantage Auto Enrollment

Referred to: Reference Committee A

Whereas, Medicare Advantage plans are promoted as providing more benefits to seniors while discounting the restrictions placed on seniors, such as narrow networks and prior authorizations; and

Whereas, seniors currently have the choice to review or change coverage annually during open enrollment; and

Whereas, there are efforts to have seniors auto enrolled in such programs, requiring them to opt out to remain in traditional Medicare actively; and

Whereas, one such plan, HR 3467, introduced by Rep. David Schweikert (R-Ariz), would automatically place seniors into the lowest premium Medicare Advantage plan in their zip code and lock them in for three years; and

Whereas, any bill that forces auto enrollment would hurt those most in need, people with cognitive impairments, low digital literacy, or limited access to trusted advisors; therefore be it

RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-26)

Introduced by: Women Physicians Section

Subject: Insurance Coverage for Scalp Cooling (Cold Capping) Therapy

Referred to: Reference Committee A

Whereas, chemotherapy-induced alopecia is one of the most distressing side effects of cancer treatment, contributing to depression, anxiety, altered body image, diminished sense of sexuality, social isolation, and reduced self-esteem, all of which significantly impair patient quality of life; and

Whereas, chemotherapy-induced alopecia can also compromise patient privacy by making a cancer diagnosis visibly apparent; and

Whereas, scalp cooling ("cold capping") is an FDA-approved therapy that significantly reduces the risk of chemotherapy-induced alopecia without compromising oncologic outcomes; and

Whereas, a meta-analysis of 501 patients demonstrated a 43% reduction in the risk of chemotherapy-induced alopecia after the use of scalp cooling; and

Whereas, a systematic review and meta-analysis of 1,959 patients receiving scalp cooling compared with 1,238 patients not receiving scalp cooling found no increase in the incidence of scalp metastases; and

Whereas, the robust body of evidence has led the National Comprehensive Cancer Network® (NCCN) to designate scalp cooling as a Category 2A recommendation, reflecting broad consensus for its use as an evidence-based intervention; and

Whereas, reimbursement for scalp cooling is inconsistent across insurance plans and geographic regions, resulting in many patients being forced to pay thousands of dollars out-of-pocket for this therapy; and

Whereas, these financial barriers affect all patients but disproportionately burden women, who are more likely to undergo chemotherapy for breast cancer and who experience greater psychosocial impact from visible hair loss due to societal expectations; and

Whereas, in 2024, New York passed Senate Bill S2063A to require private insurance companies to cover scalp cooling for chemotherapy patients; and

Whereas, in 2025, Louisiana enacted House Bill HB35 requiring coverage of integrative cancer treatments, including acupuncture, cryotherapy, and scalp cooling systems when recommended by nationally recognized cancer treatment guidelines; and

Whereas, these state-level actions demonstrate growing legislative recognition of scalp cooling as an essential component of comprehensive cancer care and establish scalable policy models

for improving equitable access to evidence-based supportive oncology interventions nationwide; and

Whereas, equitable access to supportive cancer care interventions, including scalp cooling, is integral to comprehensive cancer treatment and survivorship care; therefore be it

RESOLVED, that our American Medical Association supports insurance coverage for scalp cooling ("cold capping") for patients undergoing chemotherapy in order to minimize cost-sharing and ensure equitable access to this evidence-based intervention. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-55.966 Cancer Survivorship Program Coverage
Our AMA recognizes cancer survivorship and cancer rehabilitation as a critical component of comprehensive cancer care and supports insurance coverage for prevention and early detection of new primary cancers and recurrences, as well as for medical care services and supportive care services, including, but not limited to, genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment, aimed at managing the long-term consequences and sequelae of cancer and its treatment.

1. Our AMA advocates for work with key stakeholders to achieve adequate coverage for cancer survivorship and cancer rehabilitation care.

[Res 119, A-25]

H-55.969 Survivorship Care Plans

1. Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients.

[Res 108, A-15; Reaffirmation: A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-26)

Introduced by: Indiana

Subject: Oversight of Medicare Advantage Plan

Referred to: Reference Committee A

Whereas, the original Medicare option established in 1965, hereafter referred to as “Traditional Medicare” (TM) decreases healthcare spending and increases access to care for seniors and persons with disabilities[1]; and

Whereas, the newer Medicare Advantage (MA) program, established in 1999, allows private health insurance companies, hereafter referred to as “MA Organizations” (MAOs), to “manage” Medicare plans[2]; and

Whereas, roughly 50% of all Medicare-eligible citizens in Indiana, ~700,000 individuals, are enrolled in a Medicare Advantage (MA) plan--an increase from 40% in 2021 and 21% in 2013[3]; and

Whereas, MA plans offer more limited healthcare provider networks compared to TM, with average coverage limited to 46% of physicians in a respective county compared to over 98% of physicians who accept TM[4]; and

Whereas, MA enrollees require prior authorization for a significantly greater number of services than those enrolled in TM, with 99% of MA enrollees requiring prior authorization for necessary services such as hospital admissions and skilled nursing facilities, which starkly contrasts with the limited services requiring prior authorization in TM[5, 6]; and

Whereas, 13% of total prior authorization denials and 18% of denied payment claims issued by MA organizations would have been approved under the coverage rules of TM[5, 7, 8]; and

Whereas, repeated claims denials by MAOs have subjected patients to delays in medical care, put community and rural hospitals at risk of closure, and led some hospitals to terminate contracts with MAOs, further compromising patients' provider networks under MA plans[9, 10]; and

Whereas, federal payments to MA plan enrollees are high and annual costs were found to be $321 higher per MA enrollee than if the same enrollee had been covered by TM[11, 12]; and

Whereas, MA insurance plans have higher rates of overhead or administrative costs (13% to 18.5%) compared to TM (2%) and have a higher overhead and profit margins than even the individual market (12.3%)[13, 14]; and

Whereas, the Medicare Payment Advisory Commission (MedPAC) estimates that the current system of benchmarks and risk-adjustments has resulted in MA enrollees costing 6% more than if they had been covered by TM, a difference that is estimated to be $27 billion in 2023 alone[16]; and

Whereas, MedPAC has recommended that the Centers for Medicare & Medicaid Services (CMS) reform the current benchmark payment system to more closely align with spending within TM[17] and changes based on MedPAC recommendations are projected to reduce total Medicare spending by an estimated $82 billion dollars by 2029[11]; and

Whereas, MAOs charge taxpayers a minimum of $88 billion per year, for supplementary benefits which often attract enrollees, however, a CBO analysis completed in 2019 found that adding dental, hearing, and vision benefits to TM and Medicaid would only cost a combined $84 billion in the most expensive year of its implementation[18]; and

Whereas, the American Medical Association (AMA) has adopted Medicare Advantage Policies D-285.959 and H-330.867 to prevent access to care limitations and improve risk-adjustment for MA enrollees[17, 18]; therefore be it

RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare (New HOD Policy); and be it further

RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions (Directive to Take Action); and be it further

RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care (New HOD Policy); and be it further

RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks (Directive to Take Action); and be it further

RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

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RELEVANT AMA POLICY

Prevent Medicare Advantage Plans from Limiting Care D-285.959

1. Our American Medical Association will ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities.
2. Our AMA will advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

[Res. 706, A-21]

Medicare Advantage Plans H-330.867

1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.
2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.

[Res. 103, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-26)

Introduced by: Integrated Physician Practice Section

Subject: Ensuring Physician Input in the Development of CMMI Models

Referred to: Reference Committee A

Whereas, AMA policy is against mandatory and for voluntary CMMI models[1,2]; and

Whereas, AMA policy advocates for CMMI models that serve specialties and policies not served by current models[3]; and

Whereas, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was intended to improve the efficiency and effectiveness of healthcare using proposed solutions from frontline stakholders[4]; and

Whereas, to date, there have been no PTAC recommended models that have been tested or implemented by CMMI[5,6]; and

Whereas, CMMI has not been transparent about why PTAC recommended models are rejected for testing or implementation[7]; and

Whereas, CMMI has recently introduced a number of models including: WISeR, which for the first time placed prior authorization requirements in traditional Medicare, ACCESS, which creates a payment paradigm for digital health tools, and LEAD, which is set to succeed ACO REACH[8,9,10]; and

Whereas, “CMMI models, in aggregate, are not generating direct savings to Medicare” with some models generating substantial losses while some others do generate net savings[11]; therefore be it

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

REFERENCES

1. American Medical Association, CMMI Payment Reform Models D-385.950.
2. American Medical Association, Demonstration Project Regarding Medicare Part D H-330.894
3. American Medical Association, Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901
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RELEVANT AMA POLICY

CMMI Payment Reform Models D-385.950

Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties.
Citation: Res. 213, A-21

Demonstration Project Regarding Medicare Part D H-330.894

1. Our American Medical Association will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D).
2. Our AMA encourages the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs.

Citation: BOT Action in response to referred for decision Res. 142, A-07; Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and

Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.

4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy

Referred to: Reference Committee A

Whereas, patients, particularly pediatric patients, experience drug-resistant epilepsy, resulting in detrimental cognitive impairment[1,2], developmental delay[2–4], poor quality of life5, and increased mortality[6,7]; and

Whereas, patients who experience drug-resistant epilepsy and have failed all other therapies are candidates for stereotactic intracranial neuromodulation; and

Whereas, intracranial neuromodulation is a community standard for adult[8–11] and pediatric[12–15] patients with drug-resistant epilepsy that have failed other surgical interventions, including seizure focus resection, corpus callosotomy, vagal nerve stimulation, or cerebral hemispherectomy, or are deemed not to be candidates for surgical resection; and

Whereas**,** as many as 1 in 5 children suffer from chronic pain, with more girls than boys, and significant numbers of patients with refractory headache, back, and other pain[17]; and

Whereas**,** children who experience chronic pain and epilepsy are often denied insurance access to evidence-based neuromodulation therapies that are often available to adults because there are often multiple prospective and retrospective case series demonstrating the effectiveness of these treatments in pediatric patients, but a paucity of randomized studies in this population; and

Whereas, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) has published a position statement supporting the “off-label” use of neuromodulation in drug-resistant epilepsy in children[16]; therefore be it

RESOLVED, that our American Medical Association advocate for insurance coverage of intracranial neuromodulation as an acceptable treatment for appropriate pediatric patients with drug-resistant epilepsy (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for insurance coverage of chronic pain neuromodulation therapies such as intracranial, spinal cord and peripheral stimulation, as acceptable treatment for appropriate pediatric patients with chronic refractory pain. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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16. Neurosurgery Position Statement on Intracranial Neuromodulation for Drug-Resistant Epilepsy in Pediatric Patients August 2024. Congress of Neurological Surgeons (CNS) https://www.cns.org/advocacy/legislative-affairs-detail/new-powerpoint-204 (2024).
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RELEVANT AMA POLICY

H-120.988 - Patient Access to Treatments Prescribed by Their Physicians

1. Our American Medical Association confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88Reaffirmed: BOT Rep. 53, A-94Reaffirmed and Modified by CSA Rep. 3, A-97Reaffirmed and Modified by Res. 528, A-99Reaffirmed: CMS Rep. 8, A-02Reaffirmed: CMS Rep. 6, A-03Modified: Res. 517, A-04Reaffirmation I-07Reaffirmed: Res. 819, I-07Reaffirmation A-09Reaffirmation I-10Modified: BOT Rep. 5, I-14Reaffirmed: Res. 505, A-15Reaffirmed: CMS Rep. 6, I-20Reaffirmed: Res. 509, I-20Reaffirmation: I-22Reaffirmed: CSAPH Rep. 01, A-23Reaffirmed: CSAPH Rep. 02, A-23Reaffirmed: CSAPH Rep. 02, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-26)

Introduced by: Senior Physicians Section

Subject: Medicaid Coverage for Incarcerated Individuals

Referred to: Reference Committee A

Whereas, medical coverage for current Medicaid patients is suspended during incarceration, even for short-term periods; and

Whereas, county jails often lack sufficient resources to provide continuity of care, including current medications for individuals with chronic medical and psychiatric conditions; and

Whereas, a significant portion of incarcerated individuals are age 65 and over, and many of these individuals suffer from chronic conditions that require continuation of long-term medications; and

Whereas, abruptly stopping or altering established medication regimens can result in serious health complications, both during incarceration and upon release; therefore be it

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration, in order to prevent adverse and potentially irreversible health outcomes resulting from the discontinuation of established and evidence-based medication therapies. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/16/26

REFERENCES

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RELEVANT AMA POLICY

H-430.986 Health Care While Incarcerated

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:
    a. linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
    d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles.
15. Our AMA advocates for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited

to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay.

16. Our AMA strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections be eligible for designation as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities.
17. Our AMA advocates for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons.
18. Our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care.

[CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23; Reaffirmed: BOT Rep.05, I-24; Appended: Res. 916, I-24; Appended: Res. 918, I-24]

D-430.990 Increased Transparency Among Psychotropic Drug Administration in Prisons

1. Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.
2. Our AMA supports increased transparency from jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

[Res. 511, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-26)

Introduced by: Illinois

Subject: Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia

Referred to: Reference Committee A

Whereas, chemotherapy-induced alopecia (CIA) is one of the most visible and distressing side effects of cancer treatment, impacting patient quality of life, body image, and mental health[1, 2]; and

Whereas, scalp cooling therapy – also known as cold cap therapy – has been shown to significantly reduce the risk of CIA among patients receiving specific chemotherapy regimens for solid tumors[3]; and

Whereas, the U.S. Food and Drug Administration (FDA) has cleared several scalp cooling systems (e.g., DigniCap and Paxman) as safe and effective medical devices to reduce hair loss in patients undergoing chemotherapy[4]; and

Whereas, studies demonstrate that patients who utilize scalp cooling report improved emotional well-being and reduced psychological distress during cancer treatment[5]; and

Whereas, access to scalp cooling therapy is currently limited by a lack of insurance coverage, leading to out-of-pocket costs ranging from $1,500 to $3,000 per treatment course, exacerbating healthcare disparities among socioeconomically disadvantaged populations[6]; and

Whereas, the state of New York passed Bill A38-A/S2063-A, signed into law on December 13, 2024, requiring insurance coverage for scalp cooling systems, thereby setting a precedent for legislative action[7,8]; and

Whereas, in the Summary of Panel Actions issued on October 18, 2024, the American Medical Association (AMA) approved three CPT® Category I codes for mechanical scalp cooling, recognizing scalp cooling as an established, medically appropriate service and reinforcing its clinical significance; the new codes will be effective January 1, 2026, and included in the CPT® 2026 code set[9]; and

Whereas, the issuance of CPT® Category I codes reflects the growing acceptance of scalp cooling therapy within standard medical practice and strengthens the justification for insurance coverage by both public and private payers[9]; therefore, be it

RESOLVED, that our American Medical Association advocate for all payers to provide insurance coverage for scalp cooling systems for patients receiving chemotherapy who are at risk of chemotherapy-induced alopecia (Directive to Take Action); and be it further

RESOLVED, that our AMA engage in continued national advocacy to promote broad and equitable access to scalp cooling therapy through public and private health insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant dermatology organizations (such as the American Academy of Dermatology), oncology organizations (such as the American Society of Clinical Oncology), and other appropriate medical societies and patient advocacy groups to advance public awareness and legislative action supporting insurance coverage for scalp cooling therapy. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/18/26

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8. Paxman Scalp Cooling. Paxman Announces Passage of New York Law Requiring Insurance Coverage of Scalp Cooling Devices to Help Prevent Hair Loss During Cancer Treatment. December 16, 2024 https://paxmanscalpcooling.com/paxman-announces-passage-of-new-york-law-requiring-insurance-coverage-of-scalp-cooling-devices-to-help-prevent-hair-loss-during-cancer-treatment/
9. Paxman Scalp Cooling. Paxman Announces New CPT Category I Codes from the American Medical Association for Mechanical Scalp Cooling. October 19, 2024. https://paxmanscalpcooling.com/paxman-announces-new-cpt-category-i-codes-from-the-american-medical-association-for-mechanical-scalp-cooling/

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient. CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Quality Cancer Care Preservation Act H-330.897
Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs. BOT Action in response to referred for decision Res. 129, A-03; Reaffirmed: BOT Rep. 28, A-13; Reaffirmation A-15

Survivorship Care Plans H-55.969
Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients. Res. 108, A-15; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-26)

Introduced by: Illinois Delegation

Subject: Ensuring Coverage and Access to Adult Strabismus Surgery

Referred to: Reference Committee A

Whereas, adult strabismus affects approximately 1 in 25 adults (~4% prevalence), making it a common condition with significant functional consequences[1]; and

Whereas, adults with strabismus experience increased rates of falls, fractures, and musculoskeletal injuries due to impaired depth perception and binocular dysfunction, confirming strabismus as a functional and safety-relevant medical condition[2]; and

Whereas, the psychosocial and quality-of-life impact of adult strabismus is well documented, including impaired communication, reduced employability, and diminished social functioning[3], and research shows substantial improvement in daily functioning after surgical correction[4]; and

Whereas, adult strabismus surgery improves critical visual functions, including binocular summation, stereopsis, and fusion, leading to measurable improvements in functional vision and safety[5,6]; and

Whereas, the American Academy of Ophthalmology (AAO) Adult Strabismus Preferred Practice Pattern affirms that adult strabismus surgery is a medically necessary intervention for restoring binocular vision, alleviating diplopia, expanding visual fields, treating abnormal head posture, and improving psychosocial well-being[7]; and

Whereas, the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) Adult Strabismus Surgery Policy Statement 2025 reiterates that adult strabismus causes substantial functional, psychosocial, and safety burdens, and that surgery reliably improves diplopia, restores fusion, expands visual fields, and improves quality of life (AAPOS, 2025); therefore be it

RESOLVED, that our American Medical Association advocate for national insurer recognition of adult strabismus surgery as medically necessary, and to oppose insurer policies that misclassify such surgery as cosmetic. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/18/26

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RELEVANT AMA POLICY

Coverage for Strabismus Surgery H-185.957

Our American Medical Association supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-26)

Introduced by: Medical Student Section

Subject: Health Insurance Coverage of Hearing Devices and Related Services

Referred to: Reference Committee A

Whereas, of the approximately 28.8 million adults in the United States who could benefit from hearing devices, fewer than 20% use them, demonstrating a significant gap in utilization[1]; and

Whereas, research has shown that working-age adults (18-64 years) with untreated hearing loss experience adverse outcomes compared to those with normal hearing, including a 40% higher risk of death even after adjusting for confounding factors, greater social-situational limitations, higher rates of psychological distress, and an increased risk of dementia[2-5]; and

Whereas, the use of hearing aids has been shown to decrease difficulties in communication and social interaction among individuals after initiating use, and compared to adults with untreated hearing loss, adults who use hearing aids have decreased mortality, psychological distress, and risk of dementia[2,4,6,7]; and

Whereas untreated hearing loss among working-age adults has been associated with an estimated $193.8 billion in lost population income and $28.6 billion in unrealized federal tax revenue annually, while the use of hearing aids has been estimated to mitigate individual income loss of up to $22,000 per year[8]; and

Whereas, hearing devices and related audiological services, including diagnostic testing, fitting, and regular replacements, are inconsistently covered across private insurance plans and are typically excluded under Medicaid, making them inaccessible to many low-income adults[9-11]; and

Whereas, out-of-pocket costs for hearing aids and related services are unaffordable for 77% of Americans with functional hearing loss, and consumer surveys demonstrate that willingness to adopt hearing aids would more than double if insurance contributed to or fully covered the cost[10]; and

Whereas, adults with similar degrees of hearing loss and at least partial health insurance coverage for hearing aids are significantly more likely to acquire these devices than those without coverage, indicating that out-of-pocket cost is a barrier to adoption[16]; and

Whereas, adults with untreated hearing loss incur approximately $3,536 more in total healthcare spending over an 18-month span compared to those without hearing loss, while the average cost of hearing aids and related services is estimated to be $2,500, demonstrating that modest investments in coverage can yield meaningful healthcare savings[10,13]; therefore be it

RESOLVED, that our American Medical Association support public and private health insurance coverage of hearing services and devices, including digital hearing aids and routine replacements, for hearing-impaired adults aged 18-64. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929

Our American Medical Association supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia.
Our AMA works with interested state medical associations to support coverage of hearing exams, hearing aids, cochlear implants, and aural rehabilitative services by appropriate physician-led teams, in Medicaid and CHIP programs and any new public payers. [CMS Rep. 6, I-15 Appended: Res. 124, A-19 Appended: CMS Rep. 02, A-23 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 102, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-26)

Introduced by: Medical Student Section, Florida, Oklahoma, South Carolina, Tennessee

Subject: Opposing Alternative Funding Programs

Referred to: Reference Committee A

Whereas, Alternative Funding Programs (AFPs) are employer- or third-party vendor- benefit designs that exclude expensive medications from insurance formularies and instead require beneficiaries to enroll in manufacturer/charitable assistance programs or cover the costs themselves, thereby shifting liability outside the insurance benefit[1,10]; and

Whereas, AFPs divert limited manufacturer and charitable patient assistance funds away from uninsured and underinsured populations for whom they were intended, raising concerns about equity and sustainability of charitable assistance programs[2]; and

Whereas, in *AbbVie v. Payer Matrix*, AbbVie alleges that AFP models are misrepresenting insured patients as uninsured in a “fraudulent and deceptive scheme” to access manufacturer assistance funds, demonstrating increasing legal and regulatory scrutiny over these programs[17]; and

Whereas, as AFP adoption has grown rapidly, many patients are unaware of enrollment until coverage is denied, unexpected medical bills arrive, or medications are suddenly switched, disrupting continuity of care and undermining the physician-patient relationship[5,7]; and

Whereas, patients routed through AFPs experience significant barriers to care, including average treatment delays of 68 days to therapy, with 88% reporting associated stress or anxiety and 24% reporting worsening of their condition[6]; and

Whereas, AFPs have raised concerns regarding compliance under federal statutes, including the Affordable Care Act, the Employee Retirement Income Security Act, HIPAA, and the Anti-Kickback Statute, due to benefit misclassification, unauthorized data-sharing, and misaligned financial incentives[8,9]; and

Whereas, AFPs often circumvent Affordable Care Act regulations by reclassifying the medications as non-essential health benefits, which shifts cost liability onto patients or undermine cost-sharing safeguards by preventing copay from counting toward deductibles/out-of-pocket limits[10]; and

Whereas, copay adjustment programs, which seek to limit plan sponsor exposure to prescription drug costs by raising patient out of pocket costs, have been addressed by a growing number of state bans, so AFPs have emerged as a loophole achieving a similar effect, evading existing bans and regulations to continue affecting patient costs[3,4,16]; and

Whereas, national patient and provider organizations, including the CancerCare-led Alternative Funding Task Force, PAN Foundation, and Alliance for Patient Access, have publicly opposed AFPs and urged federal action to treat covered prescription drugs as essential health benefits

across markets and to prohibit plan designs that require enrollment in third-party assistance as a condition of coverage[11,12,13,14]; therefore be it

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs and advocate for federal and state legislation and regulation prohibiting their use. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 04/20/2026

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RELEVANT AMA POLICY

D-110.983 Alternative Funding Programs
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]

H-165.846 Adequacy of Health Insurance Coverage Options
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.
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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-26)

Introduced by: Association for Clinical Oncology, American Society of Hematology, American College of Rheumatology

Subject: Patient Continuity Protections During Payer, PBM Changes

Referred to: Reference Committee A

Whereas, specialized and complex chronic treatment regimens rely on strict adherence to clinical cycles where even a 14-day gap in therapy can result in irreversible loss of disease control, yet patients often face sudden disruptions when their payer or pharmacy benefit manager (PBM) undergoes corporate mergers, acquisitions, or contract changes; and

Whereas, these involuntary switches frequently result in the immediate cancellation of existing prior authorizations or forced non-medical switching to new preferred formularies—practices specifically opposed by the Association for Clinical Oncology 2026 Advocacy Priorities and the American Society of Hematology 2024 Access to Hematology Care in an Age of Innovation Policy Statement; and

Whereas, current AMA policy supports authorization longevity but does not explicitly mandate transition-of-care protections during corporate health plan or PBM restructuring; therefore be it

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including prior authorizations and formulary status, must be honored without interruption (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that these 90-day protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

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2. American Society of Hematology. Access to Hematology Care in an Age of Innovation. April 2024. https://www.hematology.org/advocacy/policy-statements/2019/access-to-hematology-care-in-an-age-of-innovation
3. Federal Trade Commission. FTC Secures Landmark Settlement with Express Scripts. February 2026.
4. Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. Congress Passes Landmark PBM Reform in 2026 Spending Bill. February 2026.
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RELEVANT AMA POLICY

H-320.939 Prior Authorization and Utilization Management Reform
Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation... 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes. [CMS Rep. 08, A-17; Reaffirmed: A-26]

H-125.991 Drug Formularies and Therapeutic Interchange
It is the policy of the AMA that drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings... provided they satisfy the following standards: (viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute... 2. That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process. [Res. 505, A-12; Reaffirmed: 2025]

H-125.979 Private Health Insurance Formulary Transparency
Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year... and forbidding insurance carriers from making formulary deletions within the policy term. [CMS Rep. 5, A-09; Reaffirmed: 2024]

D-110.987 The Impact of Pharmacy Benefit Managers on Patients and Physicians
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 improved transparency of PBM operations, including disclosing... records describing why a medication is chosen for or removed in the P&T committee's formulary. [CMS Rep. 5, A-19; Reaffirmed: 2025]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:116
(A-26)

Introduced by: American Academy of Pediatrics

Subject: Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs

Referred to: Reference Committee A

Whereas, the Medicaid program provides health coverage to more than 80 million Americans and represents one of the largest sources of public health care spending in the United States;[1] and

Whereas, states administer Medicaid through multiple delivery models, including state-administered fee-for-service programs, primary care case management models, and contracts with private managed care organizations (MCOs);[2] and

Whereas, as of recent federal analyses, the majority of Medicaid beneficiaries receive coverage through Medicaid managed care plans operated by private insurers under contracts with state governments;[3] and

Whereas, Medicaid managed care programs are often intended to improve care coordination, increase budget predictability for states, and promote efficient use of health care services;[4] and

Whereas, While the shift to MCOs has increased budget predictability for states, the evidence about the impact of managed care on access to care and costs is both limited and mixed;[5] and

Whereas, federal oversight agencies have identified challenges in evaluating the total costs of Medicaid managed care programs due to variations in state reporting practices and contract structures;[6] and

Whereas, physicians and health systems participating in Medicaid managed care programs frequently report significant administrative burdens associated with plan participation, including prior authorization requirements, credentialing processes, network contracting, and claims administration;[7] and

Whereas, a clearer understanding of the total fiscal and administrative implications of Medicaid managed care compared with state-administered Medicaid models would inform policymakers, physicians, and patients as states consider program design and oversight; therefore be it

RESOLVED, That our American Medical Association study and report back to the HOD at I-26 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
- Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
- The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/21/26

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RELEVANT AMA POLICY

Monitoring Medicaid Managed Care H-290.985

As managed care plans increasingly become the source of care for Medicaid beneficiaries, Our American Medical Association advocates the same policies for the conduct of Medicaid managed care that our AMA advocates for private sector managed care plans. In addition, our AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

1. Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
2. Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
3. Geographic dispersion and accessibility of participating physicians and other providers.
4. Education of beneficiaries regarding appropriate use of services, including the emergency department.
5. Availability of off-hours, walk-in primary care.
6. Coverage for clinically effective preventive services.
7. Responsiveness to cultural, language and transportation barriers to access.
8. In programs where more than one plan is available, beneficiary freedom to choose their plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
9. Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
10. Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
11. Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
12. Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
13. Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
14. Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
15. Preservation of private right of action for physicians and other providers and beneficiaries.
16. Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
17. Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
18. Absence of gag rules.
19. Fairness in procedures for selection and deselection.

20. Realistic payment levels based on costs of care and predicted utilization levels.
21. Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
22. Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.

Mandatory Enrollment of Medicare-Medicaid Patients in Managed Care Plans H-290.984
The AMA, in keeping with its support for free market competition among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Universal Out of Network Benefits

Referred to: Reference Committee A

Whereas, private health insurers have deliberately used their regional monopoly powers to push unacceptably low rates on physicians, thus creating artificially narrow networks; and

Whereas, such practice creates the appearance of physician shortages and lack of access to physicians in a reasonable time, all to the sole benefit and profit of insurers; and

Whereas, before insurers created restrictive networks, healthcare costs and premiums were much lower; and

Whereas, laws that require insurers to allow patients to seek an out-of-network physician when appropriate will always be entirely inadequate because insurers will always determine that a patient does not need an out-of-network physician; and

Whereas, the now frequent need to wait months to see a physician would largely resolve if patients all had out-of-network benefits and could see any practicing physician; and

Whereas, many states are now taking the absurd step of trying to allow nurses and physician assistants to practice medicine independently because there aren't enough in-network doctors available to care for patients; and

Whereas, the practice of creating and restricting networks has coincided with a massive increase of overall healthcare costs, not a savings; and

Whereas, the single and only beneficiary of insurance policies that offer no out-of-network benefits are the insurance companies themselves, to no clear public advantage; therefore be it

RESOLVED, that our American Medical Association will advocate for state and federal laws and regulations that require all insurers to offer plans that include out-of-network benefits. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:
    a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
    b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
    c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
    d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
    e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
    f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
    g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
    h. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmed: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Res. I-23; Reaffirmed: CMS Rep. 3, I-23; Reaffirmed: CMS Rep. 08, A-24

Patient Access to Covered Benefits Ordered by Out-of-Network Physicians D-285.958

1. Our American Medical Association will develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability.
2. Our AMA will collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

Citation: Res. 245, A-24

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Citation: Res. 108, A-17

Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963
Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.
Citation: Res. 119, A-15

Out of Network Restrictions of Physicians H-285.907
Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.
Citation: Res. 126, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-26)

Introduced by: American College of Rheumatology

Subject: Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

Referred to: Reference Committee A

Whereas, emerging state proposals to implement international reference pricing (IRP) seek to cap reimbursement for physician-administered drugs without ensuring alignment with acquisition costs; and

Whereas, such policies would risk creating negative margins for physician practices; and

Whereas, such misalignment between reimbursement and acquisition cost may force physicians, particularly in community-based and independent practices, to limit or cease offering in-office therapies; and

Whereas, a limitation or cessation of in-office therapies would reduce patient access to timely and appropriate care; and

Whereas, these policies may disproportionately impact patients with complex and chronic conditions by shifting care to higher-cost or less accessible settings; and

Whereas, international reference pricing models in other countries typically include broader health system policies and negotiation mechanisms not present in state-based proposals; and

Whereas, the American Medical Association (AMA) has established policy that any use of international price indices must preserve patient access to medications and limit burdens on physician practices; and

Whereas, existing AMA policy does not include specific advocacy goals to reduce the potential financial and administrative burdens of international reference pricing on physician practices; therefore be it

RESOLVED, that our American Medical Association remain committed to the position that international price indices or averages should not be used in isolation to set or determine prescription drug prices or payments (New HOD Policy); and be it further

RESOLVED, that our AMA work with state medical societies and specialty societies to educate policymakers on the risks of misaligned reimbursement under international reference pricing models and to promote approaches that reduce drug costs without jeopardizing patient access or practice sustainability (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-110.980 by addition to read as follows:

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.
    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 <u>by:</u>
        1. <u>Ensuring reimbursement at or above acquisition cost for physician-administered drugs.</u>
        2. <u>Protecting patient access to in-office treatments.</u>
        3. <u>Avoiding shifting care to higher-cost settings.</u>
        4. <u>Minimizing administrative and financial burdens on physician practices.</u>
    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. (Modify Current HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/21/26

RELEVANT AMA POLICY

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.
    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

Reference Committee B

Report(s) of the Board of Trustees

08 Council on Legislation Sunset Review of 2016 House Policies
12 The Uniform Health-Care Decisions Act
13 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes
14 Binding Arbitration in Health Insurance Contracts
15 Protecting the Prescriptive Authority of Plenary Licensed Physicians
19 Root Cause Analysis of the Causes of the Decline of Private Medical Practice
21 Abolishing Venue Shopping
24 AMA Advocacy to Mitigate Medicaid Cuts
25 Federal Legislation to Prohibit the Corporate Practice of Medicine
27 Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
28 Accountability in the Use of Augmented Intelligence for Prior Authorization

Resolutions

201 Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
202 Using and Defining "Unsupervised Practice of Medicine"
203 Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
204 D-400.982 Revision
205 Repeal of the Merit-Based Incentive Payment System (MIPS)
206 Overall Hospital Quality Star Ratings / CMS Star Ratings
207 Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
208 Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
209 Protecting Mental Health Treatment Privacy in Legal Proceedings
210 Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
211 Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
212 Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
213 Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
214 Medical Student Loans Should Not Be Capped
215 Oppose Medicare Efficiency Adjustments
216 Protecting Healthcare as a Sensitive Location
217 Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
218 Opposing the Practice of Jury Anchoring in Medical Liability Cases
219 Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
220 Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians

221 Universal Newborn Congenital Cytomegalovirus Screening
222 Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
223 Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
224 Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
225 Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
226 Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System
227 Standby Capacity Payments and Health IT for Hospitals in Rural Areas
228 Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
229 Physicians are not Providers
230 Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
231 Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
232 Banning Flavored Cannabis E-Cigarettes
233 Banning Synthesized, Purified or Derivative Products from Kratom
234 Physician Unity in Advocacy Regarding Physician Reimbursement
235 Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
236 Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
237 "Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan"
238 Prohibiting the Independent Practice of Medicine by Artificial Intelligence
239 Medicare Administrative Contractor Policy Modification
240 Ending Private Equity Dividend Recapitalization in Healthcare
241 Strengthening Our AMA Efforts Toward CPOM Prohibition
242 Reducing Emergency Department Boarding through Payment Reform
243 Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
244 Eliminate Administrative Barriers to Appeal Wrongful Denials
245 State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA
246 Artificial Intelligence Scope of Practice
247 Comprehensive ERISA Reform

REPORT OF THE BOARD OF TRUSTEES

BOT Report 08-A-26

Subject: Council on Legislation Sunset Review of 2016 House Policies

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

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

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

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

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

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RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-125.993	Medicare Part D Guidelines	Our AMA will continue to advocate to CMS, and if appropriate, to the United States Pharmacopeia, our AMA's Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) with respect to drug categories and classes to be covered under Medicare Part D.	Retain – this policy remains relevant.
D-140.968	Standardized Advance Directives	Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 1993, and work with our state medical societies to advocate for its adoption in the states.	Sunset this policy. The 1993 Uniform Health-Care Decisions Act from the Uniform Law Commission has been withdrawn and replaced with a more recent version. Also see Board of Trustees Report 12-A-26, which discusses this topic.
D-165.989	Managed Care Organization Reimbursement Formulas	Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.	Retain – this policy remains relevant.
D-185.982	Health Coverage for Nutritional Products for Inborn Errors of Metabolism	Our AMA: (1) will support legislation mandating insurance coverage with minimal deductible or copays for specialized medical food products used to treat inborn errors of metabolism; and (2) will advocate with the Department of Health and Human Services and members of Congress for the regulation of specialized nutritional products for the medical treatment of inborn errors of metabolism as drugs.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
D-185.993	Advocacy for Repeal of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL)	Our AMA will support state and specialty medical societies and the public health associations in their efforts to secure repeal of laws and state insurance codes which allow for the denial of insurance payments for the treatment of injuries sustained as a consequence of the insured person being intoxicated due to alcohol or under the influence of narcotics.	Retain – this policy remains relevant.
D-190.977	Insurance Reimbursements	Our AMA will: (1) seek legislation requiring managed care companies and any third party carrier including Medicare to request a refund from physicians in the same time period they give physicians to file a claim in the contract; and (2) seek legislation that managed care companies and any third party carrier including Medicare in no case be allowed more than 180 days to request a refund from a physician.	Retain – this policy remains relevant.
D-270.990	Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians	Our AMA will pursue all appropriate legislative, regulatory and legal actions to counter expansions of the scope of work by PhD clinical lab scientists and other non-physician laboratory personnel to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine.	Retain – this policy remains relevant.
D-290.998	Medicare/Medicaid Dual Eligibles	Our AMA will pursue all appropriate measures including, but not limited to, the development and passage by Congress of legislation to require the federal government to directly provide or mandate that states provide full reimbursement for Medicare deductibles and co-	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		payments for all patients who are Medicare/Medicaid dual eligible.	
D-305.972	Title VII Funding	Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.	Retain – this policy remains relevant.
D-330.904	Opposition to the CMS Medicare Policies That Undermine Access to the Best Course of Treatment ~~Part B Drug Payment Model~~	~~1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.~~ ~~2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.~~ ~~3~~1. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients. ~~4~~2. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that	Retain in part and modify the title. Sunset clauses 1 and 2; retain clauses 3 and 4. The AMA submitted a letter to Centers for Medicare & Medicaid Services (CMS) in May 2016 on the proposed Part B Drug Payment Model. Due to strong opposition, CMS did not finalize this model in 2016.

Policy Number	Title	Text	Recommendation
		impacts patient access to medical therapies, including policies on coverage and reimbursement.	
D-330.905	Expedited Review for Clerical Errors on Medicare Enrollment Applications	1. Our AMA will urge the Centers for Medicare & Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges. 2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake. 3. Our AMA will urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.	Retain – this policy remains relevant.
D-330.906	Minimize Provider Burden for Meaningful Use Audit	1. Our AMA will advocate for all audit programs to have a "look back period" of no more than two years. 2. Our AMA will advocate against the "zero tolerance" policy of the current "Meaningful Use" audit program and any similar programs proposed by the Centers for Medicare and Medicaid Services, whereby physicians lose their total incentive payment rather than receive a payment proportional to their success. 3. Our AMA will advocate to reform the Centers for Medicare and Medicaid Services "Meaningful Use" audit program.	Sunset this policy. This policy is tied to the Centers for Medicare & Medicaid Services "Meaningful Use" program, which no longer exists in its original form. The Meaningful Use incentive program for physicians ended years ago and was folded into the Merit-based Incentive Payment System under MACRA.
D-335.982	Statute of Limitations for	Our AMA will work with Medicare to reduce the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Medicare and RAC "Lookbacks"	"Lookback" period to be no longer than the length of time allowed to submit a claim for consideration.	
D-35.979	Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices	1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented. 2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same. 3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and other non-physicians in unsupervised practice. ~~comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.~~ 4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the ~~final adoption~~ of the VA's ~~proposed rulemaking~~ expanding the role of APRNs and other non-physicians within the VA in unsupervised practice.	Retain this policy with amendments. Clauses 3 and 4 should be amended.
D-355.996	Limitations on Reports by Insurance Carriers to	1. Our AMA will seek legislation and/or regulation that would require the Health Resources and	Retain in part.

Policy Number	Title	Text	Recommendation
	the National Practitioner Data Bank Unrelated to Patient Care	Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services. 2. Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's settlement of a claim that included the names of those physicians in their administrative roles at the entity. 3. Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff. ~~4. Our AMA will provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.~~	Clause 4 has been accomplished and can be deleted. Board of Trustees Report 04-I-17 on this subject was included in the 2017 Interim Meeting House of Delegates Handbook. Clauses 1-3 remain relevant.
D-390.951	CMS Revalidation of Medicare Billing Privileges	Our AMA will advocate for the Centers for Medicare & Medicaid Services (CMS) to adopt the practice of sending revalidation notices to physicians using certified mail with return receipt, thus ensuring that such notices are actually sent by CMS and received by the physician.	Sunset this policy. The Centers for Medicare & Medicaid Services has moved toward an electronic, self-service model. Notices are now sent by email in addition to U.S. mail, due dates are posted publicly months in

Policy Number	Title	Text	Recommendation
			advance, and PECOS is the primary mechanism for managing enrollment. Advocating specifically for certified mail with return receipt does not align with CMS' current direction and would likely be viewed as inconsistent with the agency's push toward modernization and paperless processes.
D-440.929	Nominations for and Improvement of the Position of the United States Surgeon General	Our AMA will convey to the Presidential Transition Team support for an enhanced role for the Surgeon General in addressing important matters of public health.	Sunset this policy. This directive has been accomplished. In 2016, the AMA met with presidential transition teams of both major party candidates to discuss their positions on a wide range of health policy issues, including public health issues that could be affected by the Surgeon General. After the election, our AMA resumed discussions with the president-elect's transition team. As part of these discussions, AMA advocated for an enhanced role for the Surgeon General that includes more resources to address matters of public health.
D-450.955	Remove Pain Scores from Quality Metrics	Our AMA will work with the Centers for Medicare & Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five-star rating system for nursing facilities.	Retain – this policy remains relevant.
D-478.982	Redefine "Meaningful Use"	1. Our AMA will work with the federal government and the Department of Health and Human	Sunset this policy.

Policy Number	Title	Text	Recommendation
	of Electronic Health Records	Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.	"Meaningful Use" has been replaced by the Promoting Interoperability (PI) Program for hospitals and, for clinicians, it is now a core component of the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).
D-480.967	Integration of Mobile Health Applications and Devices into Practice	Our AMA will: (1) assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws; and (2) assess the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps.	Retain – this policy remains relevant.
D-480.968	Telemedicine Encounters by Third Party Vendors	1. Our AMA ~~will develop model legislation and/or regulations~~ supports requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent. 2. ~~The model legislation and/or~~	Retain with amendments.

Policy Number	Title	Text	Recommendation
		~~regulations will also~~ Our AMA also supports require~~d~~ing the vendor to abide by laws addressing the privacy and security of patients' medical information 3. Our AMA ~~will include in that model state legislation~~ supports the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services. 4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.	
D-505.998	International Trade Agreements	Our AMA will: (1) monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco; (2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable	Retain – this policy remains relevant.

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

Policy Number	Title	Text	Recommendation
	Physicians' Offices as Practice of Medicine	Administration ~~remove~~ in excluding physician offices and ambulatory surgery centers from its definition of a compounding facility.	
H-120.934	Appropriate Use of Compounded Medications in Medical Offices	Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.	Retain – this policy remains relevant.
H-175.986	Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996	The AMA will work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud or abuse.	Sunset this policy. The intent of this policy—to protect physicians from malicious or unfounded fraud allegations—is comprehensively achieved through several AMA policies requiring a knowing and willful intent standard, preserving the government's burden of proof, and ensuring robust due process protections during fraud and abuse investigations. See AMA Policies H-175.981 Fraud and Abuse Within the Medicare System; H-175.985 - Kennedy-Kassebaum: Fraud and Abuse; H-235.965 - Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse; H-175.982 - Due Process for Physicians; H-330.943 - Physicians' Rights;

Policy Number	Title	Text	Recommendation
			H-175.973 - Medicare Investigation Search and Seizure Process.
H-270.953	Tax Exemptions for Feminine Hygiene Products	Our AMA supports legislation to remove all sales tax on feminine hygiene products.	Retain – this policy remains relevant.
H-270.966	Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs	Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.	Retain – this policy remains relevant.
H-270.968	Preservation of Political Advocacy by Nonprofit Organizations	The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.	Retain – this policy remains relevant.
H-290.964	CMS Audits and Clawbacks	Our AMA will undertake advocacy efforts to: 1) Persuade CMS to redefine "primary care provider" for purposes of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education Reconciliation Act of 2010 ("Section 1202"). Such definition should include the current providers board certified in a specialty considered primary care;	Sunset this policy. The temporary Medicaid "fee bump" paid to primary care providers under the ACA expired at the end of 2014. Medicaid RAC audits typically look back at payments for 3-5 years, and therefore the time period for such audits related to the ACA primary care bump has passed. For RAC audit issues unrelated to the

Policy Number	Title	Text	Recommendation
		or providers attesting to the 60% threshold under the same methodology as used in the parallel statutory formula in Section 5501(a) of PPACA; or, in states utilizing managed care organizations, providers who are, or have been held out by such MCOs as primary care providers by having patients assigned to such primary care providers and holding such providers out to the public as primary care providers; and the 60% Threshold formula previously utilized in attestation. 2) Persuade CMS to order that the audits conducted, or to be conducted, of the enhanced payments to primary care physicians, by state Medicaid agencies or their agents be conducted pursuant to the amended flexible formula redefining "primary care provider." 3) Persuade CMS to order that state Medicaid agencies, or their agents, immediately cease recoupments, or hold amounts of funds already recouped in trust, until a new audit using the redefined formula can be completed.	ACA Medicaid primary care fee bump, the AMA continues to engage in advocacy to improve the RAC audit process under Policies D-320.991 - Creating a Fair and Balanced Medicare and Medicaid RAC Program, and D-330.915 - RAC Audits of E&M Codes.
H-290.978	Medicare/Medicaid Dual Eligible Reimbursement	Our AMA seeks the repeal of Section 4714 of the Balanced Budget Act of 1997 and restore the requirement that states pay the deductible, copayment and coinsurance amounts for Medicare/Medicaid dual-eligible patients.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-330.995	Amendments to the Medicare Civil Penalties Section of the Social Security Act	The AMA supports amendment of the Social Security Act to permit trial de novo for a physician who so requests when the sum of the penalties levied is greater than $10,000 and/or when a suspension from the Medicare program is applied.	Retain – this policy remains relevant.
H-355.974	National Practitioner Data Bank	1. Our AMA will advocate to the Health Resources and Services Administration that a physician's surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.	Retain – this policy remains relevant.
H-370.968	Endorsement of the Uniform Anatomical Gift Act (2006)	Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA.	Retain – this policy remains relevant.
H-383.987	Restrictive Covenants in Physician Contracts	Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.	Retain – this policy remains relevant.
H-390.853	Protecting Patient Access to High Quality Imaging Services	Our AMA actively supports repeal or delay of the provision under Section 5102 of the Deficit Reduction Omnibus Reconciliation Act of 2005 that reduces the technical component payment (including the technical component of the global payment) for an imaging service under the physician payment	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		schedule if it exceeds (without regard to geographic wage adjustment factor) the outpatient department payment schedule amount for the service established under the Medicare prospective payment system for hospital outpatient departments.	
H-390.898	Equity in Medicare Payment Levels	Our AMA: (1) adopts as a major legislative priority the adequate funding of the Medicare program; and (2) supports the initiation of legislation to prevent any further reduction of the current Medicare limiting charges.	Sunset this policy. This policy has been superseded by AMA Efforts on Medicare Payment Reform D-400.982; Health System Reform Legislation H-165.838; Physician Payment Reform H-400.972; Sequestration D-390.946; Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program D-390.921; and Saving Traditional Medicare H-390.832.
H-40.970	The Uniformed Services University of the Health Sciences	The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences.	Retain – this policy remains relevant.
H-400.989	Physician Negotiations	The AMA supports federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-410.949	Dry Needling is an Invasive Procedure	Our AMA recognizes dry needling as an invasive procedure and maintains that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.	Retain – this policy remains relevant.
H-435.952	Savings Accounts for Extended Reporting Endorsement Policies and Other Liability Insurance Costs	Our AMA supports changes to the Internal Revenue Code to allow a pre-tax Extended Reporting Endorsement Savings Account whereby the amount of money contributed before taxes and interest on earnings from those monies be allowed to grow tax free until such time as an extended reporting endorsement must be purchased and that the balance of any remaining funds would return to the physician without IRS penalty and be subject to taxation at that time.	Retain – this policy remains relevant.
H-435.958	Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies	The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies.	Retain – this policy remains relevant.
H-435.960	Physician Relief from Product Class Actions	Our AMA: (1) asks Congress to pass legislation which prevents naming the treating physician as a party to product liability lawsuits when the treating physician has used a Food and Drug Administration-approved drug or device; and (2) promotes the introduction of legislation which would exempt physicians who have properly prescribed usage of Food and Drug Administration-approved medications from liability in class action suits	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		against pharmaceutical companies.	
H-435.967	Report of the Special Task Force and the Advisory Panel on Professional Liability	1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.	Retain – this policy remains relevant.
H-435.976	Liability Protection for Medical Volunteers	It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal.	Retain – this policy remains relevant.
H-478.985	Patient Safety Incidents Related to Use of Electronic Health Records	Our AMA supports the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center to minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses.	Sunset this policy. The Office of the National Coordinator for Health IT (ONC) efforts to implement the "Health IT Safety Center" never materialized. Instead of a centralized, independent center, ONC shifted to a collaborative approach to safety, which included SAFER (Safety Assurance Factors for Electronic Health Record Resilience) Guides, voluntary reporting, integrating safety into certification, and industry collaboration.

Policy Number	Title	Text	Recommendation
H-478.986	Merit-Based Incentive Programs	Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.	Retain – this policy remains relevant.
H-95.927	Universal Prescriber Access to Prescription Drug Monitoring Programs	Our AMA supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.	Retain – this policy remains relevant.
H-95.928	Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing	1. Our AMA supports the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame. 2. Our AMA will advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care. 3. Our AMA will work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them. 4. Our AMA will advocate for the interoperability of state PDMPs	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		with electronic health records (EHRs). 5. Our AMA will advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.	
H-95.929	Support for Prescription Drug Monitoring Programs	Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.	Sunset this policy. PDMPs are largely ubiquitous in states, and interstate interoperability, while not universal, is common. This policy is also covered by H-95.939 - Development and Promotion of Single National Prescription Drug Monitoring Program.
H-95.939	Development and Promotion of Single National Prescription Drug Monitoring Program	Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.	
H-95.986	State Legislation to Monitor Prescription of Schedule II Drugs	The AMA believes that it is important for each state to assess its own drug diversion problem and, taking into consideration the strengths of various available programs, to tailor remedial action to the specific problems of the state involved.	Sunset this policy. Each state has robust policies that accomplish this. The AMA also has multiple policies addressing the need for multifaceted state and national efforts. These include: H-95.896 - Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis; and H-95.940 - Addressing Emerging Trends in Illicit Drug Use.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 12-A-26

Subject: The Uniform Health-Care Decisions Act (Resolution 250-A-24)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

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

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

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

BACKGROUND

The ULC is a nonpartisan, non-profit association comprised of state commissions on uniform laws from each state. Members of the ULC are licensed attorneys. The ULC's purpose is "to study and review the law of the states to determine which areas of law should be uniform [and] promote the principle of uniformity by drafting and proposing specific statutes in areas of the law where uniformity between the states is desirable."[1] Importantly, the ULC drafts model legislation, but the legislation must be enacted by a state legislature to be effective.

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

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

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

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

AMA POLICY

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

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

Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," outlines the AMA's commitment to encouraging the use and awareness of advance directives and Durable Powers of Attorney for Health Care. The policy urges health care providers to educate young adults, nursing home residents, physicians, and medical students about advance directives and designating health care proxies. It promotes ensuring care plans, including advance directives, are on file and accompany patients when transferred between facilities. The policy encourages states and specialty societies to address technical issues with these documents and for medical offices to make related information easily accessible. The policy calls for collaboration

with insurers, states, Congress, and federal agencies to expand public education, include materials during Medicare enrollment and driver's license renewal, and provide incentives for advance directive completion. Additionally, it supports ongoing efforts to help physicians educate patients about advance directives and advocates for the secure electronic storage of these documents.

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

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

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

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

DISCUSSION

Advance care planning is an important aspect of ensuring patient treatment preferences are respected in the event the patient is unable to communicate their wishes. Central to respecting patient autonomy at the end of life or during incapacity is the use of advance directives, a health care power of attorney, and other advance care planning instruments. However, laws governing these instruments may vary across states and this inconsistency can create confusion, complexity, and barriers to effective health care decision-making, ultimately undermining the very goals of advance care planning. A uniform approach among state laws could help minimize confusion and

inconsistency and promote high-quality patient care and effective communication and decision-making between patients, families, and health care professionals, particularly in cases when medical decision-making may occur across state lines, amidst conflict between family members or when a patients' preferences have not been made clear. The 2023 UHCDA provides a framework for the creation, execution, and recognition of advance care planning tools, the delegation of health care decision-making, and the relevant duties of agents and health care providers. Indeed, existing AMA policy aligns with the goals of the 2023 UHCDA. However, inconsistencies between the 2023 UHCDA, AMA policy, and clinical practice raise concerns about AMA endorsement of the 2023 UHCDA.

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

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

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

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

The Board appreciates the thoughtful testimony provided at the 2025 Annual Meeting and recognizes the importance of advance care planning in ensuring that patients' treatment preferences are respected. The Board acknowledges that concerns were expressed that rescinding Policy D-140.968 would leave the AMA without direction on advance care planning and standardized advance directives. It is important to clarify, however, the scope of Policy D-140.968 and the breadth of the AMA's existing policy framework. Policy D-140.968 addresses only the AMA's endorsement of the 1993 UHCDA model act. Since the 1993 model act has been replaced by the 2023 version, Policy D-140.968 has become obsolete and should be sunset (as recommended in Board Report 8 being presented at 2026 Annual Meeting). However, sunsetting this policy would not leave the AMA without direction on advance care planning. The AMA maintains extensive and robust policy addressing advance directives, advance care planning, powers of attorney for health care, surrogate decision-making, and related issues, as detailed in the AMA Policy section of this report and Board Report 13-A-25.

The Board recognizes the desire expressed in testimony for the AMA to take a leadership role in crafting an alternative to the 2023 UHCDA. However, the Board must note that the ULC's development of the 2023 UHCDA reflects the culmination of an intensive, multi-year process led by ULC involving extensive stakeholder engagement, legal expertise, and multiple iterations of drafting and revision and consideration of complex legal, ethical, and clinical issues across diverse practice settings and state regulatory environments. Attempting to replicate or improve upon such a comprehensive effort is beyond the scope of a Board report.

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

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

RECOMMENDATIONS

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

1. That Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," be reaffirmed. (Reaffirm HOD Policy)

2. That Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," be reaffirmed. (Reaffirm HOD Policy)

3. That Policy H-85.956, "Educating Physicians About Advance Care Planning," be reaffirmed. (Reaffirm HOD Policy)

4. That Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," be reaffirmed. (Reaffirm HOD Policy)

5. That Policy H-140.826, "Use of Psychiatric Advance Directives," be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 13-A-26

Subject:	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee B

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 209, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," was introduced by the American Society of Addiction Medicine and the American Academy of Hospice and Palliative Medicine. The first item in the resolve of Resolution 209-A-25 was adopted and became Policy H-95.894 and calls for the AMA to "support legislative, regulatory, and other advocacy efforts that advance the adoption of a conjunctive standard in the context of legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice" under the federal Controlled Substances Act and implementing regulations."

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

> address relevant federal regulations to clarify that "legitimate medical purpose" means "for the purpose of preventing, treating, or managing a patient's health-related condition."

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

BACKGROUND

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

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

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- "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[6]

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

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

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

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

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

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

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

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

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

DISCUSSION

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

prescribing or other similar actions by physicians, but the Board of Trustees (the Board) points out that the adverse effects cited above occur whether or not the investigation leads to formal charges. These are some of the reasons why physicians fear the DEA and other law enforcement.

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

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

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

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

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

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

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

AMA POLICY

The AMA broadly recognizes that the nation's overdose epidemic is complicated. (H-95.981, Federal Drug Policy in the United States) AMA policy addresses the need for protections for patients with pain (D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids) as well as for individuals with an opioid use disorder. (D-95.972, Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder) AMA policy also emphasizes the need for balance by the DEA to support patients with pain while taking steps to reduce misuse and diversion of controlled substances. (D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled Substances) AMA policy also highlights the need for working with law enforcement on educational outreach with respect to "appropriate" prescribing practices, as well as efforts to help prevent

misuse and diversion. (H-95.990, Drug Abuse Related to Prescribing Practices) Finally, the AMA does not have specific policy on what constitutes a "legitimate medical purpose," although AMA policy strongly supports state regulation of the practice of medicine. (H-275.978, Medical Licensure)

CONCLUSION

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

The Board, therefore, recommends that the HOD adopt new policy that advocates for the U.S. Department of Justice (DOJ) to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a "legitimate medical purpose." The Board also recommends that the HOD adopt policy directing the AMA and its interested medical association partners to work more closely with the DOJ to clearly identify the factors that the DOJ uses during an investigation. The Board further recommends that the HOD adopt policy directing the AMA to support the CDC's Opioid Rapid Response Program and similar state-based efforts to reduce disruptions to care caused by law enforcement or other actions.

RECOMMENDATIONS

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

1. That the referred clause from Resolution 209-A-25, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," not be adopted.

2. That our American Medical Association advocate to the U.S. Department of Justice to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a legitimate medical purpose. (Directive to Take Action)

3. That our AMA advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care. (Directive to Take Action)

4. That our AMA support the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when

patients lose access to care due to a law enforcement or other action that results in the closure of a physician's practice. (New AMA Policy)

Fiscal Note: Less than $500.

APPENDIX A

Practice of Medicine – Location Defined

Summary

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

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
AL		X	**Medical Practice Act Ala. Code 34-24-50, et. Seq. "Practice of medicine or osteopathy" defined.** "The 'practice of medicine or osteopathy' means: (1) To diagnose, treat, correct, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain, or other condition, physical or mental, real or imaginary, by any means or instrumentality; **(2)** To maintain an office or place of business for the purpose of doing acts described in subdivision (1), whether for compensation or not…"
AK			**2011 Alaska Statutes Title 08. BUSINESS AND PROFESSIONS Chapter 08.64. MEDICNE Sec. 08.64.380. Definitions.** "(5) 'practice of medicine' or 'practice of osteopathy' means: (a) For a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;"
AZ		X	**Arizona Title 31 – Professions and Occupations, Chapter 13 – Medicine and Surgery, Article 1 – Arizona Medical Board 32-1401 Definitions.** "'Practice of medicine' means the diagnosis, the treatment or the correction of or the attempt or claim to be able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities or deformities, physical or mental, real or imaginary, by any means, methods, devices or instrumentalities, except as the same may be among the acts or persons not affected by this chapter. The practice

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			of medicine includes the practice of medicine alone or the practice of surgery alone, or both."
AR			**Arkansas Medical Practices Act and Regulations. Sub-Chapter 2-General Provisions. 17.95.202. Definitions.** (3) "Practice of medicine' means: (a) Holding out one's self to the public within this state as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever, (b) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly r indirectly, any fee, gift, or compensation whatsoever; (c) Maintaining an office or other place to meet persons for the purpose of examining or treating person afflicted with disease, injury, or defect of body or mind; (d) Using the title "M.D.", "M.B.", "D.O.", "physician", "surgeon", or any other word or abbreviation to indicate or induce others to believe that one is engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind, except as otherwise expressly permitted by the laws of this state relating to the practice of any limited field of the healing arts; (e) Performing any kind of surgical operation upon a human being; or (f) Delegating certain medical practices to other personnel under rules adopted by the board (g)
CA			
CO	X	X	**The Colorado Medical Board Policies, 40-27, page 101. Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine. 8/19/21.** "Providers who evaluate, treat or prescribe through telehealth technologies are practicing medicine. The practice of medicine occurs where the patient is located at the time telehealth technologies are used."
CT		X	
DE	X	X	**2021 Delaware Code Title 24 – Professions and Occupations Chapter 17. Medical Practice Act Subchapter I. General Provisions Sect 1702. Definitions.** "For the purposes of this chapter, in order that the full resources of the State are available for the protection of persons using the services of physicians, the act of the practice of medicine occurs where a person is located at the time a physician practices medicine upon the person."
DC		X	**3 DMCR § 1201.02. Definitions of health occupations.** (7)(A) "Practice of medicine" means suggesting, recommending, prescribing, or administering, with or without compensation, any form of treatment, operation,

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			drug, medicine, manipulation, electricity, or any physical, mechanical, or healing treatment by other means, for the prevention, diagnosis, correction, or treatment of a physical or mental disease, ailment, injury, condition, or defect of any person, including: (i) The management of pregnancy and parturition; (ii) The interpretation of tests, including primary diagnosis of pathology specimens, images, or photographs; (iii) Offering or performing a surgical operation upon another person; (iv) Offering or performing any type of invasive procedure of the body, whether through a body opening or a cutting of the skin, or otherwise affecting the layer of skin below the stratum corneum, for surgical, therapeutic, or cosmetic purposes, excluding procedures known as body tattooing or body piercing; (v) Rendering a written or otherwise documented medical opinion relating to the diagnosis and treatment of a person within the District, or the actual rendering of treatment to a person within the District, by a physician located outside the District as a result of transmission of the person's medical data by electronic or other means from within the District to the physician or to the physician's agent; (vi) Maintaining an office or other place for the purpose of examining persons afflicted with disease, injury, or defect of body or mind; (vii) Advertising or representing in any manner that one is authorized to practice medicine; or (viii) Using the designation "Doctor of Medicine," "Doctor of Osteopathy," "physician," "surgeon," "physician and surgeon," "M.D.," or "D.O.," or a similar designation, or any combination thereof, in the conduct of an occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of another branch of the healing arts for which one holds a valid license.
FL			**Title XXXII Regulation of Professions and Occupations, Chapter 458 Medical Practice, 458.305 Definitions** "'Practice of medicine' means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition."
GA		X	**2020 Georgia Code Title 43 – Professions and Businesses Chapter 34 – Physicians, Acupuncture, Physician Assistants, Cancer and Glaucoma Treatment, Respiratory Care, Clinical Perfusions, and Orthotics and Prosthetics Practice Article 2 – Medical Practice Sect 43-34-21. Definitions** "'To practice medicine,' 'the practice of medicine,' or 'practice medicine' means to hold oneself out to the public as being engaged in the diagnosis or treatment of disease, defects, or injuries of human beings; or the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or the maintenance of an office for the reception, examination, and treatment of persons suffering from disease, defect, or injury of body or mind;…"
GU		X	**10 GCA Health and Safety. Ch. 12 Medical Practices**

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			(b) The Healing Art means the art of prevention, detecting or attempting to detect the presence of any disease; of determining or attempting to determine the nature and state of any disease, if present; or preventing, relieving, correcting or curing of or attempting to prevent, relieve, correct or cure any disease; of safeguarding or attempting to safeguard the life of any woman or infant through pregnancy and parturition; and of doing or attempting to do any of the acts enumerated in this Subsection. The healing arts include, but are not limited to, optometry, nursing, chiropractic, dentistry, medicine and surgery, physician assistants, podiatry, psychology, osteopathic, pharmacy, physical therapy, acupuncture, speech language pathology, audiology, respiratory therapy, nutritionist/clinical dietician, cosmetology and veterinary medicine. (c) To Practice means to do or attempt to do, or to hold oneself out or to allow oneself to be held out as ready to do, any act enumerated in Subsection(b) of this Section as constituting a part of the healing art for a fee, gift, reward or in anticipation of any fee, gift or reward whether tangible or intangible.
HI			**Hawaii Revised Statues 453-1-Practice of medicine defined** "… the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines; surgery; manual medicine; water; electricity; hypnotism; telehealth; the interpretation of tests, including primary diagnosis of pathology specimens, medical imaging, or any physical; osteopathic medicine; any means, method, or agent, either tangible or intangible, to diagnose, treat, prescribe for, palliate, or correct disease, or prevent any human disease, condition, ailment, pain, injury, deformity, illness, infirmity, defect, physical or mental condition in the human subject."
ID		X	**Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1803. Definitions.** "'Practice of medicine' means: (a) The investigation, diagnosis, treatment, correction, or prevention of or prescription for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality that involves the application of principles or techniques of medical science; or (b) Offering, undertaking, or holding oneself out as able to do any of the acts described in paragraph (a) of this subsection." **Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1844. Definitions.** "'Practice of medicine' means the clinical prevention, diagnosis or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the medical practice act of a member state"
IL		X	**225 ILCS 60/49.5. From ch. 111, par 4400-38** (e) An out-of-state person providing a service listed in Section 49 to a patient residing in Illinois through the practice of telemedicine submits himself or herself to the jurisdiction of the courts of this State.
IN		X	**IC 25-22.5-1-1.1 Definitions.** "(a) 'practice of medicine or osteopathic medicine' means any one (1) or a combination of the following

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			2) The maintenance of an office or a place of business for the reception, examination, or treatment of persons suffering from disease, ailment, defect, injury, infirmity, deformity, pain, or other conditions of body or mind. 4) Providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services: A) are transmitted through electronic communications; and B) are on a regular, routine, and nonepisodic basis or under an oral or written agreement to regularly provide medical services. In addition to the exceptions described of section 2 of this chapter, a nonresident physician who is located outside Indiana does not practice medicine or osteopathy in Indiana by providing a second opinion to a licensee or diagnostic or treatment services to a patient in Indiana following medical care originally provided to a patient while outside Indiana.
IA		X	**Chapter 148 Medicine and Surgery and Osteopathic Medicine and Surgery. 148.1 Persons engaged in practice.** 148.1 Persons engaged in practice. For the purpose of this subtitle, the following classes of persons shall be deemed to be engaged in the practice of medicine and surgery or osteopathic medicine and surgery: 1. Persons who publicly profess to be physicians and surgeons or osteopathic physicians and surgeons, or who publicly profess to assume the duties incident to the practice of medicine and surgery or osteopathic medicine and surgery. 2. Persons who prescribe, or prescribe and furnish, medicine for human ailments or treat the same by surgery
KS		X	**Healing Arts Act 65-2802. 65-2869. Persons deemed engaged in practice of medicine and surgery.** a. Persons who publicly profess to be physicians or surgeons, or publicly profess to assume the duties incident to the practice of medicine or surgery or any of their branches. b. Persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder, of human beings.
KY		X	**311.500 Definitions for KRS 311.530 to 311.620 and 311.990(4) to (6)** Except as provided in subsection (11) of this section, the 'practice of medicine or osteopathy' means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;
LA		X	**2011 Louisiana Laws Revised Statutes TITLE 37 – Professions and occupations RS 37:1262 – Definitions.** "The practice of medicine," whether allopathic or osteopathic, means the holding out of one's self to the public as being engaged in the business of, or the actual engagement in, the diagnosing, treating, curing, or relieving of any bodily or mental disease, condition, infirmity, deformity, defect, ailment, or injury in any human being, other than himself, whether by the use of any drug, instrument or force, whether physical or psychic, or of what other nature, or any other agency or means; or the examining, either gratuitously or for compensation, of any person or material from any person for such purpose whether such drug, instrument, force, or other agency or means is applied to or used by the patient or by another person; or the attending of a woman in childbirth without the aid of a licensed physician or midwife.

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ME		X	**2021 Maine Revised Statutes: Title 32: Processions and Occupations. Chapter 48: Board of Licensure in Medicine. Subchapter 3: General Provisions. Sect. 3300-D. Interstate practice of telemedicine.** 5. Jurisdiction. In registering to provide interstate telehealth services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State.
MD		X	**Statutes Article – Health Occupations Sect. 14-101** (O) (1) "Practice medicine" means to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery. 2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following: (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. By appliance, test, operation, or treatment; (ii) Ending of a human pregnancy; and (iii) Performing acupuncture as provided under sec. 14-504 of this title.
MA			**243 CMR: Board of Registration In Medicine. 243 CMR 2.00: Licensing and the Practice of Medicine. 2.01: Scope and Construction** The Practice of Medicine means the following conduct, the purpose or reasonably foreseeable effect of which is to encourage the reliance of another person upon an individual's knowledge or skill in the maintenance of human health by the prevention, alleviation, or cure of disease, and involving or reasonably thought to involve an assumption of responsibility for the other person's physical or mental well being: diagnosis, treatment, use of instruments or other devices, or the prescribing, administering, dispensing or distributing of drugs for the relief of diseases or adverse physical or mental conditions. (a) A person who holds himself or herself out to the public as a physician or surgeon, or with the initials "M.D." or "D.O." in connection with his or her name, and who also assumes responsibility for another person's physical or mental well being, is engaged in the practice of medicine (b) The Practice of Medicine includes the following: 1. Telemedicine, as defined in 243 CMR 2.01: Telemedicine; and 2. Providing an independent medical examination or a disability evaluation.
MI		X	**Mich. Comp. Laws § 333.17001 Definitions; principles of construction.** (j) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.
MN		X	**147.081 PRACTICING WITHOUT LICENSE; PENALTY. Subd. 3.Practice of medicine defined.**

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			For purposes of this chapter, a person not exempted under section 147.09 is "practicing medicine" or engaged in the "practice of medicine" if the person does any of the following: (1) advertises, holds out to the public, or represents in any manner that the person is authorized to practice medicine in this state; (2) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another; (3) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person; (4) offers or undertakes to perform any surgical operation including any invasive or noninvasive procedures involving the use of a laser or laser assisted device, upon any person; or (5) offers to undertake to use hypnosis for the treatment or relief of any wound, fracture, or bodily injury, infirmity, or disease.
MS	X	X	**MS Admin. Code Title 30, Part 2635, Rule 5.2.** "The practice of medicine is deemed to occur in the location of the patient."
MO			**Title XII Public Health and Welfare. Chapter 191. 191.1145. Definitions** 3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.
MP			**Title 185: Commonwealth Health Care Professions Licensing Board. Chapter 185-10 Commonwealth Health Care Processions Licensing Board Regulations. Part 4200 – Physician – Doctor of Osteopathy. Sect 185-10-4201 Definitions** (dd) "Practice of Medicine" means: (1) Holding out one's self to the public as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever; (2) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly or indirectly, any fee, gift or compensation whatsoever; (3) The maintenance of an office or other place to meet persons for the purpose of examining or treating persons afflicted with disease, injury, or clinical defect of the body or mind; (4) Using the title "Doctor," "Doctor of Medicine," "Doctor of Osteopathy," "Physician," "Surgeon," "Dr.," "M.D.," "D.O.," or any word or abbreviation to indicate or induce others to believe that one is engaged in the practice of medicine defined herein; (5) Performing any kind or surgical operation upon a human being.
MT		X	**Montana Code 2021 Title 37 Professions and Occupations Chapter 3. Medicine Part 1. General Definitions 31-3-102** "Practice of medicine" means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or

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			mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.
NC			**Chapter 90 Medicine and Allied Occupations. Article 1. Practice of Medicine. Sect 90-1.1. Definitions.** The practice of medicine or surgery. - Except as otherwise provided by this subdivision, the practice of medicine or surgery, for purposes of this Article, includes any of the following acts: a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State. b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual. c. Offering or undertaking to prevent or diagnose, correct, prescribe for, administer to, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition. d. Offering or undertaking to perform any surgical procedure on any individual. f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone.
ND		X	**Chapter 43-17 Physicians and Surgeons. 43-17-01. Definitions.** 5. "Practice of medicine" includes the practice of medicine, surgery, and obstetrics. The following persons are regarded as practicing medicine: a. A person that holds out to the public as being engaged within this state in the diagnosis or treatment of diseases or injuries of human beings. b. A person that suggests, recommends, or prescribes any form of treatment for the intended relief or cure of any physical or mental ailment of any individual, with the intention of receiving, directly or indirectly, any fee, gift, or compensation. c. A person that maintains an office for the examination or treatment of individuals afflicted with disease or injury of the body or mind.
NE		X	**Nebraska Revised Statute 38-2024 Practice of Medicine and Surgery, defined.** Persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state.
NH		X	**Title XXX Occupations and Professions. Chapter 329 Physicians and Surgeons. Section 329:1-d Telemedicine.** II. An out-of-state physician providing services by means of telemedicine shall be deemed to be in the practice of medicine and shall be required to be licensed under this chapter.
NJ		X	**NJ State Board of Medical Examiners Law. Article 1 Practice of Medicine and Surgery in General. 45:9-5.1. Definitions.**

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			"the practice of medicine or surgery" and the phrase "the practice of medicine and surgery" shall include the practice of any branch of medicine and/or surgery, and any method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition
NM			**NM Statutes Annotated. Sec. 61-6-6-(K).** "The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state, to the physician or the physician's agent, OR the rendering of treatment to a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician's agent."
NV		X	**NRS 630.020 "Practice of medicine" defined.** "Practice of medicine" means: 1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy. 2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions. 3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics, including, without limitation, through telehealth, from within or outside this State or the United States. **NRS 629.515** Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient, the provider must hold a valid license or certificate to practice his or her profession in this State
NY			**NY Education Law Article 131, Medicine. Sect 6521. Definition of practice of medicine.** The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.
OH		X	**State medical Board of Ohio Position Statement on Telemedicine** The "practice of telemedicine" is defined in Ohio as the practice of medicine in this state through the use of any communication, including oral, written or electronic communication, by a physician located outside this state.
OK		X	**Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act. Tite 59 O.S., Sect. 492. Practice of Medicine and Surgery – Title - Hospital** C. The definition of the practice of medicine and surgery shall include, but is not limited to: b. Except as provided in subsection D of this section, performance by a person within or outside of this state, through an ongoing regular arrangement, of diagnostic or treatment services, including but not limited to, stroke prevention

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			and treatment, through electronic communications for any patient whose condition is being diagnosed or treated within this state. A person who performs any of the functions covered by this subparagraph submits himself or herself to the jurisdiction of the courts of this state for the purposes of any cause of action resulting from the functions performed.
OR			**Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.085** What constitutes practice of medicine. A person is practicing medicine if the person does one or more of the following: (1) Advertise, hold out to the public or represent in any manner that the person is authorized to practice medicine in this state. (2) For compensation directly or indirectly received or to be received, offer or undertake to prescribe, give or administer any drug or medicine for the use of any other person. (3) Offer or undertake to perform any surgical operation upon any person. (4) Offer or undertake to diagnose, cure or treat in any manner, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person. (5) Except as provided in ORS 677.060, append the letters "M.D." or "D.O." to the name of the person, or use the words "Doctor," "Physician," "Surgeon," or any abbreviation or combination thereof, or any letters or words of similar import in connection with the name of the person, or any trade name in which the person is interested, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions mentioned in this section. **Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.135** "Practice of medicine across state lines" defined (1) The rendering directly to a person of a written or otherwise documented medical opinion concerning the diagnosis or treatment of that person located within this state for the purpose of patient care by a physician or physician assistant located outside this state as a result of the transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant; or (2) The rendering of medical treatment directly to a person located within this state by a physician or a physician assistant located outside this state as a result of the outward transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant.
PA		X	
PR			
RI		X	**Licensure and Discipline of Physicians (216-RICR-40-05-1) 1.2 Definitions.** "Practice of medicine" means the practice of allopathic and osteopathic medicine. Any person shall be regarded as practicing medicine within the meaning of the Act who holds himself or herself out as being able to diagnose, treat, perform surgery, use a laser/intense pulsed light, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal

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			physical or mental condition, or who shall either profess to heal, offer or undertake, by any means or method, to diagnose, treat, perform surgery, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition. In addition, one who attaches the title M.D., physician, surgeon, D.O., osteopathic physician and surgeon, or any other similar word or words or abbreviation to his or her name indicating that he or she is engaged in the treatment or diagnosis of the diseases, injuries or conditions of persons shall be held to be engaged in the practice of medicine. Non-ablative treatment is part of the practice of medicine.
SC			**Title 40 – Professions and Occupations Chapter 47 Physicians and Miscellaneous Health Care Professionals. Article 1 General Provisions. Section 40-47-10. 36.** "Practice of Medicine" means: (a) Advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in this State; (b) Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person; (c) Offering or undertaking to prevent or to diagnose, correct or treat in any manner, or by any means, methods, or devices, disease, illness, pan, wound, fracture, infirmity, defect, or abnormal physical or mental condition of a person, including the management of pregnancy and parturition; (d) Offering or undertaking to perform any surgical operation upon a person; (e) Rendering a written or otherwise documented medical option concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within this State by a physician located outside the state as a result of individual patient data by electronic or other means from within a state to such physician or his agent
SD		X	**Chapter 36-2 Practitioners of Healing Arts in General. 36-2-1. Definition of terms.** "Healing art," "healing," "art of healing," "practicing healing," "practicing of healing," any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, unhealthy or abnormal physical or mental condition;
TN		X	**2010 Tennessee Code Title 63 – Professions of the Healing Arts. Chapter 6 – Medicine and Surgery. Part 2 – General Provisions. 63-6-204 – Practice of medicine defined.** (a) (1) Any person shall be regarded as practicing medicine, within the meaning of this chapter, who treats, or professes to diagnose, treat, operates on or prescribes for any physical ailment or any physical injury to or deformity of another.
TX		X	**Occupations Code. Title 3. Health Professions. Subtitle B. Physicians. Chapter 151. General Provisions. Subchapter A. General Provisions. Sec. 151.002. Definitions.**

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			(13) "Practicing medicine" means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or attempt to effect cures of those conditions…
UT		X	**Utah Medical Practice Act. Part 1 – General Provisions. 58-67-102. Definitions.** (12) (a) "Practice of medicine" means: (i) to diagnose, treat, correct, administer anesthesia or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, including to perform cosmetic medical procedures, or to attempt to do so, by any means or 2 instrumentality, and by an individual in Utah or outside the state upon or for any human within the state; (ii) when a person not licensed as a physician directs a licensee under this chapter to withhold or alter the health care services that the licensee has ordered; (iii) to maintain an office or place of business for the purpose of doing any of the acts described in Subsection (12)(a) whether or not for compensation;
VT		X	**26 V.S.A. Sect. 1311. Definitions.** (1) "Practice of medicine" means: (F) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within the State by a physician located outside the State as a result of the transmission of individual patient data by electronic or other means from within the State to the physician or his or her agent;
VI			**Title 27, Chapter 1, Subchapter IIa. Telehealth Act. Sect. 45d Telemedicine Licensure.** (b) No person shall practice or attempt to practice medicine at a distant site between the Virgin Islands and another United States jurisdiction without first complying with the provisions of this subchapter and without being a holder, of a Virgin Islands medical license.
VA	X		**Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine. P. 2 & 4-5 (Aug. 19, 2021).** The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located.
WA	X	X	**RCW 18.71.011 Definition of practice of medicine - Engaging in practice of chiropractic prohibited, when.** A person is practicing medicine if he or she does one or more of the following: (1) Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality; (2) Administers or prescribes drugs or medicinal preparations to be used by any other person; (3) Severs or penetrates the tissues of human beings; **Telehealth in Washington State | Washington State Department of Health** Telehealth care takes place where the patient is located at the time of the appointment.

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

Last Updated: September 2022

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

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 14-A-26

Subject: Binding Arbitration in Health Insurance Contracts (Resolution 208-A-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

DISCUSSION

General Differences Between Binding Arbitration and Litigation

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

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

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

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

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

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Commonly Discussed Pros and Cons of Arbitration

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

Potential Advantages of Arbitration

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

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

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

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

Potential Disadvantages of Arbitration

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

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

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

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

The Federal Arbitration Act and State Arbitration Laws

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

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

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

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

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

disfavoring contracts that (oh so coincidentally) have the defining features of arbitration agreements."[3]

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

Amending the Federal Arbitration Act

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

The AMA Should Provide Resources to Physicians

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

CONCLUSION

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

RECOMMENDATION

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

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

Fiscal Note: Less than $500.

REFERENCES

[1] *Southland Corp. v. Keating*, 465 U.S. 1, 10 (1984)
[2] *Kindred Nursing Centers Limited Partnership v. Clark*, 581 U.S. 246, 250 (2017)
[3] *Id* at 251
[4] A recent example was the 2022 enactment of the Ending Forced Arbitration of Sexual Assault and Sexual Harassment Act (Act) which was first introduced in 2017. The Act prohibits employers from requiring employees or contractors to arbitrate sexual assault or sexual harassment claims.

REPORT 15 OF THE BOARD OF TRUSTEES (A-26)
Protecting the Prescriptive Authority of Plenary Licensed Physicians
Reference Committee B

EXECUTIVE SUMMARY

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 204-A-25, "Protecting the Prescriptive Authority of Plenary Licensed Physicians," was adopted. This resolution resulted in Policy D-120.920, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," which directed the AMA" to study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy."

This report provides background on legal and clinical requirements for valid prescriptions, examines the shared responsibilities of physicians and pharmacists, provides available data and related information, and outlines relevant AMA policy.

While pharmacists play an essential role on physician-led care teams, particularly in ensuring medication safety, concerns arise when pharmacists refuse to dispense prescriptions based on judgments outside their education and training. Such refusals can contribute to patient harm, including uncontrolled symptoms, relapses or debilitation, and additional harm. At the same time, this report affirms the pharmacist's legal and ethical obligations and their "corresponding responsibility" to verify prescription validity, including resolving technical errors and addressing safety concerns or so-called "red flags."

This report also highlights how corporate policies and pharmacy benefit management company requirements can also compel pharmacists to refuse to fill legitimate prescriptions, effectively overriding individual professional judgment.

Finally, this report emphasizes the need for improved communication between physicians and pharmacists and renewed engagement with national pharmacy organizations. This report highlights that existing AMA policy strongly supports physician-led teams, recognizes the important role of pharmacists, and opposes inappropriate pharmacy intrusion into medical practice.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-A-26

Subject: Protecting the Prescriptive Authority of Plenary Licensed Physicians

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

1. Our AMA will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.

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

BACKGROUND

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

- Name, address, phone number of the prescribing physician;
- Full name and address of the patient (also known as the "ultimate user");
- The drug name and strength;
- Specific directions for use, including number of times per day and number of days total;
- Quantity of the drug to be dispensed;
- Number of refills authorized by the prescriber;
- Whether the prescriber allows for substitutions, including generic versions, or whether the prescription shall be dispensed as written;
- The prescriber's signature, which may be required to be manually written, or for electronic prescriptions, additional requirements that help protect against fraud or forgery;

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- Other information, such as diagnostic codes, may be required by a state;[1]
- Prescriptions for controlled substances have additional requirements, including the prescriber's DEA number;[2] and
- Electronic prescriptions for controlled substances also have additional requirements.[3]

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

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

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

For the purposes of this report, the Board considers an "effective prescription" to carry equivalent weight and meaning as when discussing a "valid prescription." The CSA makes clear that there are mutual, complementary roles for the physician and the pharmacist. While the physician carries the primary responsibility for ensuring a prescription's validity, the pharmacist has a corresponding responsibility to ensure the prescription's validity. In fulfilling the corresponding responsibility, as physicians commonly experience, the pharmacist may ask questions of the patient and the physician to help ensure the medication prescribed meets the necessary safety requirements per the pharmacist's education and training. Per the CSA, the ultimate decision whether to fill and dispense a prescription, rests with the pharmacist.

DISCUSSION

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

the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.[6]

Potential Conflicts that Arise

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

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

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

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

Similarly, if a pharmacist contacts the physician to alert the physician that the patient has multiple prescriptions for the same medication from different prescribers, the Board sees this as an opportunity to improve continuity of care and support patient safety. Even though the Board opposes inappropriate pharmacy intrusions into the practice of medicine, we also know that beneficial physician-pharmacist communication occurs on a regular basis. Moreover, if a pharmacist determines—based on the pharmacist's education and training, combined with additional information from the prescriber and patient—that the prescription is not for a legitimate medical purpose issued in the usual course of professional practice, the Board acknowledges that the pharmacist may legally refuse to dispense that medication.

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

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

National Prevalence and Patterns of Pharmacists Refusing to Fill Valid Prescriptions

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

There also is limited data with respect to specific medical conditions. A 2022 American Society of Addiction Medicine study, for example, found that 45 percent of respondents said that a "pharmacy or pharmacist declined to fill the prescription for buprenorphine."[15] Among the

reasons given for the denial: (1) concern that the prescription was clinically inappropriate; (2) corporate policy limiting or prohibiting dispensing of medication; or (3) belief that the Drug Enforcement Administration (DEA) has a cap on the quantity of buprenorphine that can be dispensed. While most patients were able to ultimately have their prescription filled at a different pharmacy, 14 percent could not get their prescription filled. The outcome for those patients is unclear.

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

While these studies show that inappropriate actions by pharmacists do occur, the limited number makes it challenging to identify specific patterns or national prevalence of such actions. There is certainly anecdotal information concerning refusals to fill medications for pain or OUD because of a physician's scope of practice—and the AMA has been clear in its opposition, including drafting model state legislation to help prevent corporate pharmacy interference in the practice of medicine. The AMA has shared this model state legislation with multiple medical societies, and the AMA Advocacy Resource Center is available to support any state interested in pursuing such legislation.

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

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

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

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

AMA POLICY

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

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

Finally, while the AMA strongly supports pharmacists playing an integral role as part of a physician-led health care team, AMA policy "deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted. (H-35.961, "AMA Response to Pharmacy Intrusion into Medical Practice").

CONCLUSION

Refusing to fill a valid prescription issued in the usual course of professional practice for a legitimate medical purpose risks patient harm. If a pharmacist has a question to help ensure the accuracy and safety of a prescription, it is important for pharmacists to feel confident in reaching out to the prescribing physician. This does not mean, however, that pharmacists should seek information that is beyond their education and training. Nor does it mean that pharmacists have a right to refuse to fill and dispense a prescription solely because pharmacists do not agree that a

physician's specialty matches what the pharmacist expects for a given prescription. Physician-pharmacist conflicts are rare, but the Board understands that they occur—and that it is incumbent upon all of us to work together for our patients' health and safety.

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

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

RECOMMENDATIONS

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

1. That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas. (Directive to Take Action)

2. That our AMA urge pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).

3. That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed. (Reaffirm HOD Policy)

4. That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows:

   ~~1. Our American Medical Association will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.~~

   1.1. Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

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

4.3. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.

5.4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care. (Modify Current HOD Policy)

Fiscal note: Less than $500.

REFERENCES

[1] See, Ohio Administrative Code Rule 4729-5-30 Manner of issuance of a prescription.
[2] 21 CFR § 1306.04. Purpose of issue of prescription.
[3] Guidance on Implementing the e-Prescription Mandate in P.A. 103-0425. Illinois Department of Financial and Professional Regulation. Available at https://www.isms.org/ISMS.org/media/ISMSMediaLibrary/documents/IDFPReprescription.pdf
[4] 42 CFR § 455.440. National Provider Identifier.
[5] National Provider Identifier Standard (NPI). Centers for Medicaid and Medicare Services. September 10, 2024. https://www.cms.gov/regulations-and-guidance/administrative-simplification/nationalprovidentstand
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REPORT 19 OF THE BOARD OF TRUSTEES (A-26)
Root Cause Analysis of the Causes of the Decline of Private Medical Practice

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical Practice" was adopted by the House of Delegates (HOD). This policy directs the American Medical Association (AMA) to study and report back on the root cause of the decline in private practice (including but not limited to: the declining inflation-adjusted Medicare rates, Stark laws, the permitted consolidation of insurers and hospitals, hospital-insurer agreements that are minimal for physicians who are in-network compared with out-of-network, increased government influence by insurers and hospitals and decreased influence by doctors, inadequate formal education on the business of medicine, educational debt of early career physicians, evolving lifestyle preference of early career physicians, overhead expenditures, and hospital-based facility fees). This report examines contributing factors in the decline of private practice—organized into four categories: economic pressures, market consolidation, administrative and regulatory burden, and generational workforce factors.

Economic pressures were divided into two categories: (1) those that reduce practice revenue such as declining inflation-adjusted Medicare reimbursement and (2) those that increase practice costs such as overhead expenditures (e.g., EHRs, personnel, and administrative costs). The report highlights how consolidation among hospitals and commercial insurers affects the sustainability of independent physician-owned practices, including hospital-insurer agreements with minimal in-network fee requirements, conditions such as high hospital technical fees, and insurance plans without out-of-network benefits. The report notes that, as consolidation increases, resulting shifts in alignment and influence may further dilute the voice of physicians in private practice.

The report further examines how increased market consolidation can amplify the disproportionate impact of administrative and regulatory burdens on smaller and independent practices, as physicians in larger systems may have dedicated compliance infrastructure to manage these requirements (e.g., EHR interoperability, value-based payment reporting, and billing code changes). Additionally, it addresses generational workforce factors contributing to the decline of private practice, such as increasing retirement rates of "baby-boomer" physicians, younger physicians' lifestyle preferences and stronger focus on work-life balance, personal financial considerations, and limited business education. Finally, an analysis is provided of how several of these factors dynamically interact, contributing to a reinforcing feedback loop.

In addition to categorizing and analyzing factors driving the decline of private medical practice, this report also lists relevant AMA efforts including Medicare payment reform advocacy, educational resources and programs, research, and policy.

Given the AMA's substantial efforts in advocating for and developing resources concerning the preservation of private medical practice, the AMA recommends that (1) several existing policies be reaffirmed (Reaffirm HOD Policy), (2) the AMA identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions (New HOD Policy), (3) Policy D-405.965 be rescinded (Rescind HOD Policy), and (4) the remainder of the report be filed.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 19-A-26

Subject: Root Cause Analysis of the Causes of the Decline of Private Medical Practice

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

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

BACKGROUND

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

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

The U.S. health care system overall has undergone significant change in the last several decades, including rising health care costs, continued downward pressure on payment, wide adoption of EHRs and other technology, the rise of chronic disease burden and more complex care, and more recently, the downstream effects of a global pandemic. During this period, many private practices have been acquired by hospitals and health systems. Drivers of this shift were recorded by the 2022 AMA Physician Practice Benchmark Survey, where 80 percent of physicians whose practices were acquired indicated that the need to better negotiate favorable (higher) payment rates with payers was a very important (46.1 percent) or important (33.4 percent) reason as to why their practice was sold to or acquired by a hospital or health system. The need to better manage payers' regulatory and administrative requirements and improve access to costly resources were both reported by approximately 70 percent of physicians as a very important or important reason for selling their practice.[6]

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

DISCUSSION

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

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

Economic Pressures

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

Declining Inflation-Adjusted Medicare Rates

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

Overhead Expenditures such as EHRs, Personnel, and Administrative Costs

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

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

Under the standard reimbursement system for traditional fee-for-service Medicare, in addition to physician payment through the MPFS "facility" rates, hospital outpatient departments (HOPDs) (with some exclusions) receive payment for ambulatory services under the OPPS. Clinicians rendering services in freestanding physician-owned offices receive payment through the MPFS "non-facility" rates, and the private practices do not receive payment through OPPS. This is the so-called "site-of-service differential." For example, in 2023, an initial preventative exam was reimbursed at a 51 percent higher rate in an existing HOPD than in a freestanding physician-owned office.[10] Another study addressing the commercial insurance market in 2022 found that on average, total payment for an ambulatory service in a HOPD was 145 percent more than in a physician office.[11] The "site-of-service differential" can advantage hospital-based outpatient services compared to those in free-standing physician offices.

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

Market Consolidation

Horizontal consolidation pertains to the situation when organizations in a common market, delivering the same services, combine. For example, this happens when two hospitals in the same city merge, or when one large health insurer buys out a smaller insurer that covers the same

population. This type of consolidation decreases competition and leads to the increased pricing power of the dominant entities.

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

The Permitted Consolidation of Insurers and Hospitals

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

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

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

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

- Most Favored Nation (MFN) Clause
- Non-compete Clause
- All-or-nothing Clause
- Anti-tiering/Anti-steering Clause
- Gag Clause (Price Secrecy Provision)
- Exclusive Contracting Clause[17]

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

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

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

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

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

Administrative & Regulatory Burdens

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

The Physician Self-Referral (Stark) Law

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

Administrative Burdens

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

The cumulative time devoted to administrative tasks not directly related to patient care has been a major contributor to physician dissatisfaction and burnout.[19] In smaller practices, physicians often personally handle or oversee these requirements, whereas larger organizations are able to delegate

to specialized administrative personnel. The increasing complexity of federal, state, and payer requirements—especially regarding EHR interoperability, value-based payment reporting[20], and frequent changes to billing codes—has raised the cost of compliance and further strained private practice viability.

Generational Workforce Factors

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

Inadequate Formal Education on Business Skills

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

Evolving Lifestyle Preference of Early Career Physicians

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

Educational Debt of Early Career Physicians

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

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

Interplay of Factors

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

Private Practice Margins are Compressed by Economic Pressures

Most private, independent physician-owned practices are small, so efficiencies gained from economies of scale are not available to decrease overhead costs. Therefore, the effects of decreasing reimbursement rates and loss of revenue streams to larger consolidated health care organizations are causing a continued loss of the margin required to financially sustain practice. Innovative mitigation of financial risk is hindered by regulatory burdens as costs associated with compliance are significant and burdensome. In addition, the lack of formal business education also hampers physicians from finding solutions to these economic stressors although even formal business education would not negate the realities of the economic imbalance, decreasing revenues, increasing costs, and restrictive structural barriers (e.g., increasing administrative and regulatory burdens).

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

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

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

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

AMA RESOURCES AND ACTIVITIES

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

Medicare payment reform advocacy

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

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

Additionally, in Section 6225 of the Consolidated Appropriations Act, 2026—a government bill recently signed into law—Congress included a provision that's consistent with AMA Policy D-330.891, "Transparency of Facility Fees for Hospital Outpatient Department Visits" which advocates for (1) legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at HOPD designated clinics and (2) the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service. Section 6225 requires all off-campus outpatient departments to obtain separate, unique National Provider Identifiers and submit an attestation confirming compliance with provider-based regulations by January 1st, 2028, or otherwise face the loss of OPPS payments.[26]

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

Monitoring of market dynamics

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

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

Decreasing administrative and regulatory burdens

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

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

Support of Private Practice

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

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

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

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

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

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

AMA POLICY

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

Medicare Reimbursement

Regarding the importance of improved Medicare and Medicaid reimbursement, the AMA (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; notes that (4) if the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases (Policy H-330.932, “Cuts in Medicare and Medicaid Reimbursement”).

The AMA will also (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; (3) work with CMS to develop consistent

regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery; (4) support the Current Procedural Terminology (CPT®) Editorial Panel / RVS Update Committee (RUC) recommendation to the Centers for Medicare & Medicaid Services (CMS) to separately pay for high-cost supplies priced more than $500; and (5) work with the federal government to address flaws in the Medicare Physician Fee Schedule practice expense methodology resulting in reimbursement being less than direct costs for hundreds of services in the office-based setting (Policy H-400.957, "Medicare Reimbursement of Office-Based Procedures").

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

Site-of-Service Differential

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

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

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

Further, the AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a

legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments (Policy D-330.997, "Appropriate Payment Level Differences by Place and Type of Service").

Inflation-Based Physician Payment

On the topic of inflation-adjusted physician payment rates, AMA policy states that it shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule and to maintain a level of payment that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes inflation-based updates; and AMA will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment Schedule (Policy D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule").

Additionally, AMA supports policy that increases and maintains access to health care for all, payment for physicians under Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than 100 percent of RBRVS Medicare allowable (Policy H-385.921, "Health Care Access for Medicaid Patients).

Health System & Insurance Consolidation

AMA has numerous policies regarding health system and insurance consolidation. For instance, the AMA (1) will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government; and this AMA annual report on nationwide hospital consolidation will be modeled after the "Competition in health insurance: A comprehensive study of U.S. Markets" in its thoroughness to include for example data and analyses as: (a) a review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets; (b) a list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation; (c) analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets; and (d) analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place. AMA will report the initial findings of this study to the House of Delegates by Annual 2024 and the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy (Policy D-160.907, "Health System Consolidation").

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

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

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

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

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

Further, the AMA affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) strongly supports and encourages competition in all health care markets; (c) supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and antitrust relief for physicians remains a top AMA priority. AMA will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices (Policy H-215.960, "Hospital Consolidation").

It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b)clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. AMA will also work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services (Policy H-215.969, "Hospital Merger Study").

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

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

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

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

Preservation of Private Practices

Concerning the preservation of private practice, AMA policy states that the AMA (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training

with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices (Policy D-405.988, "The Preservation of the Private Practice of Medicine").

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

Administrative Burdens

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

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

CONCLUSION

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

Understanding the interplay between the factors is also helpful in identifying and prioritizing effective interventions.

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

RECOMMENDATIONS

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

1. That our AMA reaffirm the following policies:
    a. H-330.932, “Cuts in Medicare and Medicaid Reimbursement”;
    b. H-400.957, “Medicare Reimbursement of Office-Based Procedures”;
    c. H-390.879, “Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service”;
    d. D-330.902, “The Site-of-Service Differential”;
    e. H-240.958, “Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service”;
    f. D-240.994, “Payment Variations Across Outpatient Sites of Service”; D-330.997, “Appropriate Payment Level Differences by Place and Type of Service”;
    g. D-400.990, “Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule”;
    h. H-385.921, “Health Care Access for Medicaid Patients”;
    i. D-160.907, “Health System Consolidation”;
    j. D-215.984, “Health System Consolidation”;
    k. H-180.947, “Maintaining Freedom of Choice with Insurance Products”;
    l. D-160.906, “Strengthening Efforts Against Horizontal & Vertical Consolidation”;
    m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”;
    n. D-385.940, “Stark Law Self-Referral Ban”;
    o. H-215.960, “Hospital Consolidation”;
    p. H-215.969, “Hospital Merger Study”;
    q. D-225.995, “Hospital Merger Study”;
    r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”;
    s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”;
    t. H-160.960, “Corporate Ownership of Established Private Medical Practices”;
    u. D-405.988, “The Preservation of the Private Practice of Medicine”;
    v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”;
    w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”;
    x. H-110.985, "340B Drug Discount Program"; and
    y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy)
2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy)
3. That Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice” be rescinded as being accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

APPENDIX:

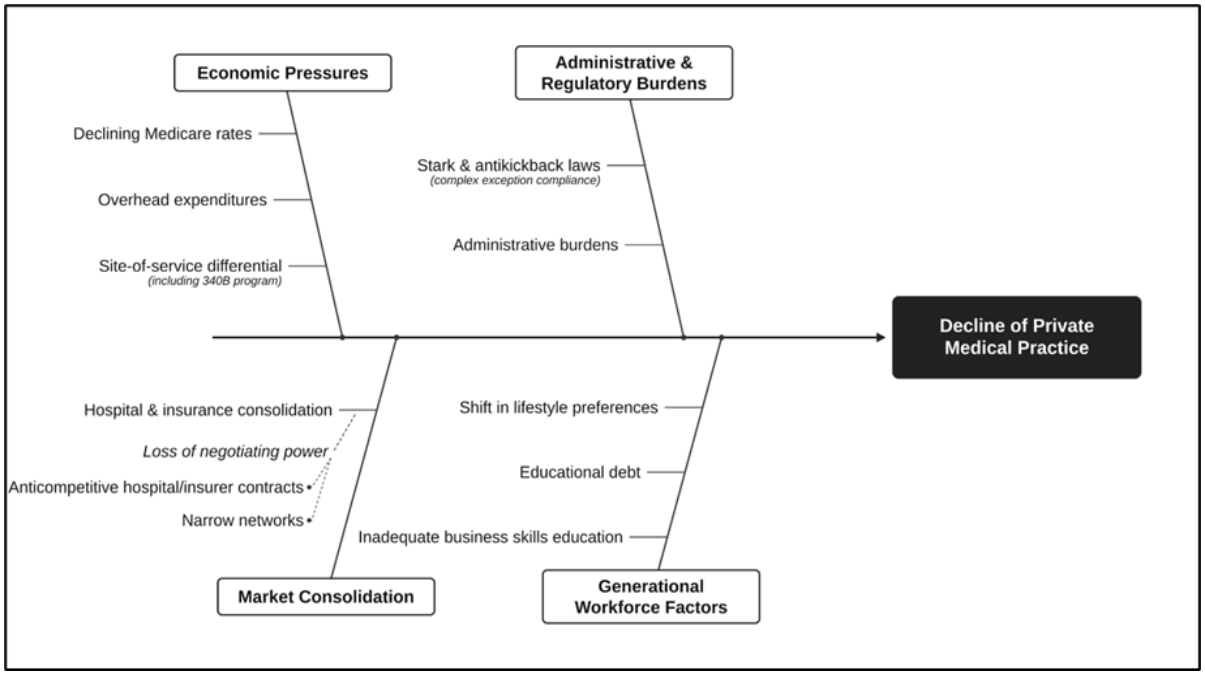


Figure 1: Basic root cause analysis fishbone diagram[7] used by report authors to organize the factors outlined in Policy D-405.965 into overarching thematic categories.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 21-A-26

Subject: Abolishing Venue Shopping
(Resolution 207-A-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

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

BACKGROUND

Medical liability reform has long been one of the AMA's advocacy priorities. Although physicians and patients are not yet experiencing the kind of national medical liability insurance crisis that occurred in the early 2000s, over the last few years there has been a significant increase in the size of medical liability awards. In fact, the U.S. has seen an increase of "nuclear verdicts" in medical liability cases, i.e., cases where the jury awarded $10 million or more, some exceeding $25 million. This is worrisome to the Board of Trustees (the Board) because such awards are often influenced by factors that have nothing to do with a physician's alleged negligence or patient injury. Oftentimes they are the product of "social inflation," such as eroding trust in the U.S. health care system and the perceived corporatization of medicine. There also appears to be a return of hard medical liability insurance markets in parts of the country.

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In addition to what has been described above, the Board knows that venue shopping, also known as forum shopping, can be a major contributor to increasing medical liability exposure. Venue shopping occurs when a plaintiff's attorney can file medical liability lawsuits in a county where juries are known for awarding large medical liability awards, even if the county has no connection to underlying facts of the lawsuit. Venue shopping is an abuse of the judicial process, as it leads to outsized awards that must be absorbed by physicians in the form of increased medical liability insurance premiums, ultimately to the detriment of patient access.

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

State Medical Liability Lawsuits and Forum Shopping: The Pennsylvania Example

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

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

During its medical liability crisis, Pennsylvania pursued at least two strategies to combat venue shopping. First, Pennsylvania enacted 42 Pa.C.S.A. § 5101.1. This statute required medical liability cases to be filed "only in a county in which the cause of action arose." This statute was, however, declared unconstitutional in *North-Central Pennsylvania Trial Lawyers Association v. Weaver*, 827 A.2d 550 (Pa. Cmmwth. 2003) on the grounds that Pennsylvania's judicial branch of government, rather than the Pennsylvania General Assembly, was constitutionally authorized to set venue rules.

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

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

2023, 43 percent of 657 medical malpractice complaints that were initiated in Philadelphia County were based on care provided outside the city.[1]

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

Venue Shopping and Resourced-Based Standards of Care

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

Federal Medical Professional Liability Actions and Venue Shopping

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

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

DISCUSSION

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

First, enacting a statute that restricts where medical professional liability lawsuits may be filed is one strategy to combat venue shopping. As the *Weaver* case illustrates, however, such statutes may be subject to constitutional challenges. Importantly, the Board notes that while this is what happened to Pennsylvania's statute, the situation may be different in other states. For example, in 2005, Missouri enacted R.S,Mo. § 508.010, as part of a comprehensive

medical liability reform package. Section 508.010 establishes venue under different scenarios for both non-tort and tort claims (e.g., medical professional liability lawsuits). Section 508.010 states in part that, "Notwithstanding any other provision of law, in all actions in which there is any count alleging a tort and in which the plaintiff was first injured in the state of Missouri, venue shall be in the county where the plaintiff was first injured by the acts or conduct alleged in the action."

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

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

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

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

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

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

Thus, based on Pennsylvania Supreme Court precedent and the fact that Ms. Somerlot consented to venue in Bucks County by signing the venue selection clause, the court transferred the case from

Philadelphia County to Bucks County. Based on this case, the Board believes that this contractual approach is a strategy to combat venue shopping that may also be available in other states.

CONCLUSION

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

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

RECOMMENDATION

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

1. That our American Medical Association amend Policy D-438.968, "Abolishing Venue Shopping" by deletion of clause 2 as it has been accomplished by this report:

    1. Our American Medical Association (AMA) opposes venue shopping in medical professional liability actions.

    ~~2. Our AMA will study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26.~~ (Modify Current Policy)

2. <u>That our AMA will work with interested medical society partners, to combat venue shopping in medical liability lawsuits.</u> (New HOD Policy)

3. That our AMA opposes any efforts to move venue to jurisdictions that may apply a standard of care not reflecting specific resource constraints, available technology/equipment and community standards of the location where the patient's clinical care was actually delivered. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 24-A-26

Subject: AMA Advocacy to Mitigate Medicaid Cuts

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

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

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

BACKGROUND

Summary of Medicaid Cuts

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

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

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

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

The law also established a new source of federal funding, the Rural Health Transformation Program, intended to offset impacts of reduced Medicaid spending in rural areas. However, the $50 billion program is time limited and falls short of fully replacing lost funding from OBBBA. As a result, many states will still face significant challenges maintaining access to care, supporting physician practices, and sustaining safety-net health care infrastructure.

Impact and Response

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

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

PUBLIC DENUNCIATION OF MEDICAID CUTS

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

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

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

ENGAGEMENT WITH STATE MEDICAL ASSOCIATIONS AND NATIONAL MEDICAL SPECIALTY SOCIETIES

Convening the Federation of Medicine

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

The AMA also convened multiple national webinars and briefing calls for state medical associations and national medical specialty societies focused on the Medicaid provisions in OBBBA. These sessions provided timely analysis of statutory changes, implementation timelines, and state-level decision points. Specifically, in August, the AMA convened state and specialty medical association staff at the AMA State Advocacy Roundtable for a focused discussion on approaches to implementing the law's Medicaid provisions and identifying shared priorities across the Federation. During the fall, the AMA hosted two national calls for state medical associations and specialty societies on the Rural Health Transformation Program, with particular attention to its interaction with state scope of practice laws. The AMA also hosted a publicly available Advocacy

Insights webinar in November, attended by nearly 800 participants, which examined the effects of the law on patients and physicians and identified key points of influence for the AMA and other medical organizations. In December, the AMA conducted a Federation-wide webinar on Medicaid provider taxes, examining the details of provider tax rollbacks and outlining state policy options to mitigate funding losses. Additional briefings and educational sessions were held for state medical association audiences, AMA Sections, and allied organizations. Medicaid policy and implementation challenges were also a central focus of strategy discussions at the 2026 AMA State Advocacy Summit, including engagement with Medicaid officials regarding state-level implementation considerations.

Development and Dissemination of Policy Tools and Resources

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

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

Individualized State-Level Technical Assistance

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

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

COLLABORATION WITH STATE AND NATIONAL STAKEHOLDERS

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

FEDERAL ADVOCACY AND REGULATORY ENGAGEMENT

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

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

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

ONGOING EFFORTS

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

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

STRATEGIC PRIORITIES GOING FORWARD

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

CONCLUSION

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

RECOMMENDATION

The Board of Trustees recommends that the fourth item of Policy D-290.970, "Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts," be rescinded as having been accomplished by this report and the remainder of the report be filed.

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

Fiscal note: Less than $500.

REFERENCES

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

REPORT 25 OF THE BOARD OF TRUSTEES (A-26)
Federal Legislation to Prohibit the Corporate Practice of Medicine
(Reference Committee B)

EXECUTIVE SUMMARY

Resolution 225, which was referred at the 2025 Interim Meeting, would support federal legislation banning the corporate practice of medicine (CPOM), provided it does not weaken existing state laws, and would seek to prohibit non-physician-owned entities from participating in federal health care payment programs.

The CPOM doctrine provides a legal framework to protect physicians from undue corporate influence in the delivery of health care. CPOM laws are variable and historically implemented at the state level, but a lack of enforcement activity combined with regulatory loopholes has limited the impact of state CPOM laws. However, there is momentum in state legislatures to reinvigorate the doctrine, and AMA supports state medical associations seeking to modernize CPOM legislation at the state level.

A federal CPOM prohibition is attractive insofar as it would clarify the doctrine and create a uniform set of baseline requirements, assuming that courts apply the doctrine of federal preemption to establish the desired federal floor. However, it is unclear whether a single uniform set of federal standards around CPOM would appropriately address the variable needs of each state. Moreover, the federal government may not be optimally equipped to enforce CPOM laws, whose violations tend to be granular and local in nature. Finally, the law's preemptive effect would be litigated, and it is difficult to predict what courts will find in the context of a particular state requirement. Absent statutory mechanisms that bolster enforcement, a federal CPOM bill could thereby result in ineffectual legislation that disrupts local health care markets, without the desired preemptive effect.

Banning non-physician-owned entities from participating in payment programs such as Medicare may disproportionately impact physicians over corporate owners, decrease access to care, and harm competition in health care markets. As a tool to increase leverage over violators of a CPOM prohibition, it creates a high degree of risk.

Ultimately, a categorical ban on CPOM is unlikely to achieve the intended effect without careful calibration. A more stable path for a federal CPOM prohibition might protect core elements of clinical independence and include specific, carefully crafted language reflecting the intent to preserve state flexibility to enact and enforce stricter requirements. This would likely limit federal preemption, which would protect physician autonomy without creating a rigid national standard around ownership structure that may be unevenly enforced or misaligned with local realities of care delivery. Additionally, a whistleblower program for violations of such a provision could strengthen enforcement efforts.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 25-A-26

Subject: Federal Legislation to Prohibit the Corporate Practice of Medicine
Resolution 225-I-25

Presented by: David Aizuss, MD, Chair

Referred to: Reference Committee B

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

> RESOLVED, That our American Medical Association advocate for federal legislation that prohibits lay corporations, including insurance companies, private equity firms, and other non-physician-owned entities, from owning or controlling medical practices and healthcare decision-making, and prohibits such entities from participation in federal healthcare payment programs, in order to protect physician autonomy and strengthen the physician-patient relationship (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA amend Policy H-215.981 – Corporate Practice of Medicine under items #1 and #2 by addition and deletion as follows:
>
> 1. Our American Medical Association ~~vigorously opposes any effort to pass federal legislation or regulation preempting state laws~~ supports the passage of federal legislation prohibiting the corporate practice of medicine.
>
> 2. Our American Medical Association vigorously opposes any effort to pass state or federal legislation or regulation that removes or weakens existing state laws prohibiting the corporate practice of medicine.

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

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BACKGROUND

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

Corporate Involvement in Physician Practices

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

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

Without guardrails, corporate investment may disrupt high-quality, coordinated care delivered by a physician-led team, and many believe it decreases access and competition.[5] Corporate investment in health care is also thought to accelerate consolidation in medical specialties, which changes the practice landscape for physicians and can drive down physician wages while increasing health care costs for patients.[6]

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

The CPOM Doctrine

The CPOM doctrine refers to a long-standing legal precept intended to preserve the independent clinical judgment of physicians and safeguard patient care from undue corporate influence. At

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

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

Regulation of CPOM

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

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

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

Frequently, these state bills aim to strengthen CPOM provisions by setting discrete parameters for what constitutes corporate interference with medical practice and clearly establishing oversight. Many would also implement provisions to address the MSO loophole, for example by requiring that physicians who contract with an MSO retain meaningful control over clinical decisions or prohibiting certain types of dual affiliation between the leadership of an MSO and a practice with which the MSO contracts. Indeed, both California and Oregon recently enacted legislation that limits MSOs from controlling physicians' clinical or operational decisions, and novel provisions in

Oregon's bill impose requirements that erode "friendly physician" arrangements.[13] Related state legislation, including bills in Massachusetts and California,[14] among other states, would promote transparency around corporate involvement in health care by authorizing designated state agencies to review or approve health care transactions involving corporate entities—these bills bolster existing CPOM bans by shining light on transactions that may pose a threat to physician autonomy and providing a clear basis for the exercise of state enforcement authority.

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

The Option for a Federal CPOM Ban

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

A One-Size-Fits-All Standard

A federal CPOM ban would establish a single, easily understood law nationwide, which would consolidate the doctrine and reduce legal complexity. However, uniformity risks destabilizing health care markets. Because variations in state laws governing CPOM reflect the unique characteristics of local health care economies, a single federal CPOM standard is unlikely to address the specific needs of physicians in every state. Pursuit of a workable standard would require careful, nuanced distinctions between arrangements that support physician autonomy and those that factually undermine it, which may prove more aspirational than practical. A federal rule risks interference with existing state-tailored solutions, potentially harming physician autonomy, patient access to care, and the stability of health care markets that have evolved to meet local needs.

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

Federal Preemption

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

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

The preemption analysis is fact-specific and interpretively complex, making it difficult to predict.[21] Complicating this, once a bill is introduced in Congress, large scale amendments are often made, some of which fundamentally change the nature of the original text. The likelihood of state authority being preserved increases if the final federal statute includes an explicit clause permitting stricter state laws, but the actual preemptive effect will depend on judicial interpretation of specific statutory provisions and the extent to which Congress intended to occupy the field or restrict supplemental state regulations. The floor envisioned by Resolution 225-I-25 is certainly possible with careful drafting; however, it is also possible that a federal CPOM ban could result in state laws being preempted and replaced with a federal standard that may be less protective than existing requirements.

Federal Enforcement of a CPOM Ban

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

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

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

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

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

Resolution 225-I-25 seeks policy banning all non-physician entities—which may include hospitals and integrated health systems in addition to many private-equity backed groups and other corporate investors—from participating in federal health care payment programs like Medicare. The Board of Trustees (the Board) infers that the intent behind this proposal is to add leverage to enforcement of CPOM provisions, given precedent set by the Anti-Kickback Statutes, which grant the Office of the Inspector General (OIG) authority to bar individuals found guilty of violating the statute from participating in Medicare and state health care payment programs.[29]

In the context of CPOM, the Board notes that this policy would have significant and probably unintended consequences. Conditioning Medicare payment on CPOM compliance could suspend Medicare billing for an entire practice; however, depending on the practice agreement it is possible that it would to disproportionately punish physicians over corporate owners. Where physician payment arrangements are based on Relative Value Unit or salary/bonus models, physicians may be shielded and the corporate entity would be penalized. However, Medicare privileges generally sit with the individual physician, not the upstream practice owners, thus targeting financial penalties would be preferable to Medicare participation/privilege. Thus, this policy could disrupt physician income streams while penalizing clinicians who may not control or even have clear

knowledge of their practice's specific ownership structure or the details of any agreements in place that may violate CPOM provisions.

Finally, lack of clarity around what constitutes "ownership" would need to be addressed as state laws vary widely—once this is done, the consequences described here may be disproportionately severe in some states. As previously debated in the HOD, the litmus test could be operational authority at the most basic level.

While in theory, conditioning Medicare participation on CPOM compliance would create leverage for enforcers, it also risks harm to physicians and patients, uneven enforcement, and destabilization of practice infrastructure. In addition, the Board is concerned that proposing a broad-stroke federal CPOM prohibition may have some risk of unintended consequences, especially of jeopardizing existing state regulations and laws that may be stricter than what can be realistically passed federally. Thus, any proposal would need to account for a phase-in period and the need for carefully calibrated policies that address the concern of preemption and appropriately targeted penalties.

AMA's Support of Private Practice Physicians

While legislation provides one avenue for protecting physicians from corporate influence in their practice, and AMA actively supports states seeking to enact strong CPOM laws, action can also be taken at the practice level, for example in careful contracting with any corporate partners. Because many corporate investments in independent practice have not been positive, the AMA has offered guidance to assist physicians with required due diligence in any contractual arrangement with private equity firms, venture capital, and hedge funds.

The High-Performing Private Practice Initiative (the Initiative) was launched in 2021 to enhance the AMA's efforts to address a concerning downward trend in physician practice ownership. The Initiative created essential resources to support private practice. Between 2021 and 2022, the Initiative developed the Private Practice Web Toolkit, the Simple Solutions educational series, the Thriving in Private Practice podcast, and the Private Practice Playbook v1.0. Further, the Navigating Practice program introduced medical students to independent practice as a viable career path. By 2023-2024, programming expanded with the STEPS Forward® Attending to Business podcast and an updated Private Practice Playbook v2.0. The June 2024 Business of Medicine Workshop represented a pivotal evolution from passive resources to active business education. Resources to support physician practices in matters related to CPOM include a series on venture capital and private equity investment, one component of which is a contracting toolkit for physicians entering arrangements with corporate investors.[30]

Notably, in the fall of 2026, the AMA will launch the Independent Practice Accelerator—a two-day intensive workshop distilling essential competencies through expert sessions, case studies, and peer networking. This accessible format will provide physicians exploring or beginning independent practice with foundational knowledge in strategic planning, obtaining capital, business fundamentals, revenue cycle management, operations, leadership, and marketing. By preserving physician choice and practice model diversity, the program advances the AMA's core mission of removing obstacles to patient care and ensuring high-quality care delivery.

DISCUSSION

Well-founded concerns about erosion of clinical autonomy underscore the desire for a federal CPOM prohibition that creates a uniform federal standard upon which state law may build.

However, a categorical ban on CPOM is unlikely to achieve the intended effect without careful calibration, because uniform structural requirements around physician ownership could require the unwinding of existing physician practice arrangements that may be working. However, if it is working, it is possible that an arrangement would still work under an appropriately tailored CPOM law that would be beneficial to both parties. Further, broad substantive requirements are difficult for federal agencies to enforce, and a federal prohibition raises preemption concerns. In addition, conditioning participation in federal health care payment programs on CPOM compliance would have consequences that disproportionately impact physicians and patients rather than corporate owners. Existing AMA policy opposes the corporate practice of medicine and tends to support AMA engagement on this issue.

AMA POLICY

Current AMA policy opposes the corporate practice of medicine as well as efforts to weaken or remove existing laws or regulations prohibiting CPOM, acknowledging that the corporate practice of medicine can erode the patient-physician relationship. It offers guidance to physicians seeking relationships with corporate entities, including examples of activities that constitute clinical decisions that must remain under the control of the physician.

AMA Policy H-215.981, "Corporate Practice of Medicine" states that:

1. Our AMA vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

Policy H-160.887, "Corporate Practice of Medicine," acknowledges that the corporate practice of medicine has the potential to erode the patient-physician relationship and may create a conflict of interest between profit and best practices in residency and fellowship training.

Policy H-160.891, "Corporate Investors and Other Corporate Entities," offers the following guidelines for physicians contemplating corporate entity relationships:

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
    h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
    j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
        i. Determining which diagnostic tests are appropriate;
        ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
        iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
        iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
        v. Determining the content of patient medical records;
        vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
        vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;

viii. Making decisions regarding coding and billing procedures for patient care services; and
ix. Approving the selection of medical equipment and medical supplies.

k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

CONCLUSION

The Board understands the urgency with which corporate intrusion on the practice of medicine needs to be addressed, and appreciates that at present, state enforcement of CPOM bans is largely lacking. At the same time, we acknowledge certain risks and limitations associated with a federal approach. However, given the importance of this issue, we support the notion that the AMA should take an active stance against corporate intrusion on the delivery of care at both the state and federal level. A more stable path for federal engagement on CPOM might pursue a narrowly tailored federal law to protect core elements of clinical independence, and craft it carefully to include language reflecting an intent to preserve state authority to enact and enforce related and more stringent laws. Especially if associated with a whistleblower program to add leverage to federal enforcement activity, this model would protect physician autonomy without risking destabilization of state health care markets, while leaving room for states to implement and enforce related provisions.

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the remainder of this report be filed:

1. That the American Medical Association, in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned

entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws. (New HOD Policy)

2. That the AMA support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency. (New HOD Policy)

3. That the AMA support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine (New HOD Policy)

4. That Policy H-215.981, "Corporate Practice of Medicine," be amended by addition and deletion as follows:

~~1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.~~

1.~~2.~~ Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.

2.~~3.~~ Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.

3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

4.~~5.~~ Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.

5.~~6.~~ Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected.

6.~~7.~~ Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

7.~~8.~~ Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.

8.~~9.~~ Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to

physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify Current HOD Policy)

Fiscal Note: Less than $500.

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[10] Id.
[11] OR SB 951 (2025), amended by OR HB 3410 (2025); *See also* CA SB 351 (2025)
[12] Among the states where legislation related to CPOM has been introduced are Connecticut, Rhode Island, New Jersey, Maine, and New Mexico.
[13] *Supra* note 11.
[14] MA HB 5159 (2025) and CA SB 351 (2025)
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REPORT OF THE BOARD OF TRUSTEES

BOT Report 27-A-26

Subject: Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS (Res. 819-I-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 819, "Update the Status of Virtual Credit Card Policy, Electronic Funds Transfer (EFT) Fees, and Lack of Enforcement of Administrative Simplification Requirements by the Centers for Medicare & Medicaid Services (CMS)," was adopted as amended and became Policy D-190.965. It asked the following:

> Our American Medical Association report at the Annual 2026 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

Testimony before the Reference Committee was limited but uniformly supportive. Delegates expressed continued concern that, despite sustained AMA advocacy, the financial burden associated with virtual credit card (VCC) payments and EFT processing fees persists and, in some cases, has intensified. Testimony highlighted the cumulative impact of these fees on physician practices, particularly small and rural practices operating on narrow margins. An amendment was offered to require that the progress report be delivered one year earlier than originally proposed and to specify that the report include concrete "action items" outlining the AMA's regulatory and legislative strategy. Delegates emphasized the urgency of the issue and the need for visible enforcement of existing Administrative Simplification requirements by CMS. The Reference Committee recommended adoption of the resolution as amended, and the House concurred.

BACKGROUND

To reduce paperwork and streamline business processes across the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent policies adopted certain national standard transactions for the electronic exchange of health care data. These transactions included EFT payments and electronic remittance advice. Beginning in the early 2000s, health plans began transitioning from issuing paper checks to using electronic payment methods for physicians.

This shift was significantly accelerated by the Patient Protection and Affordable Care Act (ACA) of 2010, which included provisions aimed at increasing administrative efficiency, notably the establishment of a standard for EFT. Under this requirement, health plans had to offer physician practices the option to receive payments via the Automated Clearing House (ACH) Network. Health plans may use clearinghouses and other vendors to meet their obligation to offer standard

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electronic transactions. Health plans and their vendors have sought alternatives to the ACH EFT standard since its adoption, which compete with and deter adoption of electronic transactions as envisioned by the ACA. Health plans or their vendors have leveraged flexibility in the EFT final rule, which permits nonstandard electronic payments using VCCs. VCCs are often promoted as the easiest and quickest form of payment, despite significant processing fees. Alternatively, plans or their vendors force physicians to accept additional "value-added services" and associated percentage-based fees with EFT payments. The fees that health plans and their vendors charge practices for simply receiving electronic payments create significant administrative burdens and divert funds that could otherwise support patient care.

Challenges around electronic transactions from health plans and clearinghouses were further exacerbated by the Change Healthcare cyberattack in February 2024 and the subsequent service outage. The Board of Trustees is well aware of the financial and administrative burdens that this unprecedented cyber event placed on physician practices and patients nationwide. The AMA was actively engaged with Optum and Change Healthcare to address ongoing issues related to the disruption and requested increased flexibility in the recoupment of payments on loans to practices, as well as in meeting timely claim-filing deadlines for the period when Change Healthcare's systems were non-functional, and practices were unable to file claims.

Unfortunately, the cyberattack and outage also compromised existing electronic transaction enrollments with vendors and clearinghouses, requiring re-enrollment to protect patient and physician data. Issues with the timing, costs, and other obstacles facing practices in re-enrolling to receive electronic transactions, such as EFT, hampered the recovery from the cyberattack. When EFT enrollments expired, many health plans and their vendors did not contact physician practices in advance to facilitate swift re-enrollment; instead, they automatically defaulted to VCC or fee-based EFT payments. Overall, the cyberattack and its aftermath only compounded the challenges and burdens that physician practices have long faced with electronic transaction fees.

AMA POLICY

The AMA has longstanding policy on VCCs and EFT electronic processing fees. First, the Board of Trustees notes three policies that are particularly relevant to the discussion that focus on increasing education around the use of VCCs in physician practices, as well as advocacy that promotes advance disclosure by payers of transaction fees and physician access to no-fee EFT options as an alternative to VCCs:

Policy H-190.955, "Virtual Credit Card Payments"

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Policy D-190.970, "CMS Administrative Requirements"

1. Our American Medical Association will forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA).
2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees.
3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.
4. Our AMA will through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Policy D-190.968, "Amend Virtual Credit Card and Electronic Funds Transfer Fee"

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:
    a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
    b. CMS enforcement activities related to this issue.
    c. Physician access to a timely no fee EFT option as an alternative to VCCs.

AMA policy provides a clear and longstanding framework for addressing virtual VCC payments EFT fees, and enforcement of Administrative Simplification requirements. In 2015, the House of Delegates adopted Policy H-190.955, which commits the AMA to educating physicians about the costs and mechanics of VCC payments, promoting advance disclosure of transaction fees and payer incentives, and protecting physician choice through an initial opt-in model, meaningful opt-out rights and opposition to contractual provisions that require acceptance of VCCs as a condition of network participation.

In 2022, the AMA adopted Policy D-190.970, directing the AMA to advocate that CMS investigate and resolve violations of HIPAA Administrative Simplification requirements, ensure transparency in enforcement processes, and oppose improper payment practices, including illegal EFT fees and failure to provide compliant payment options.

In 2023, the AMA adopted Policy D-190.968, which strengthens this framework by promoting physician access to a timely, no-fee EFT option, opposing excessive EFT add-on service fees, urging CMS to clarify physicians' right to receive basic EFT payments without additional charges, and supporting robust enforcement of existing regulatory standards.

Together, these policies, adopted in 2015, 2022, and 2023, establish a comprehensive advocacy foundation centered on transparency, physician autonomy, regulatory enforcement, and protection against improper transaction fees. They provide the basis for the AMA's ongoing regulatory and legislative efforts to ensure physicians can receive timely electronic payments without coercive practices or unnecessary financial loss.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 819 and recognizes the challenges that VCCs and electronic processing fees pose for physician practices. AMA advocacy is squarely focused on addressing these issues from both the regulatory and legislative perspectives.

For example, in June 2025 and July 2025 letters to Department of Health and Human Services (HHS) and CMS, the AMA emphasized how VCCs and fee-based EFT payments continue to pose significant problems for physicians, as these payment methods impose fees (up to five percent of the claim amount) that can add up to substantial financial losses to practices that are already struggling. Physician practices that lose up to five percent of claims payments due to EFT fees are less able to invest in the additional staff, medical equipment, data analytics, and information technology that could improve care access and quality. This is an especially salient issue for rural physician practices operating on thin margins, which are already struggling to provide timely care without having to factor in the greater administrative burdens and fees that come with receiving electronic payments. The AMA has continued to raise these concerns in subsequent federal discussions and stakeholder engagement.

In addition, these fees represent a reduction in the negotiated rate the health plan has agreed to pay the physician for a rendered service. Moreover, VCC and EFT fee programs are often opaque, with many physicians unaware of the associated financial losses until months after being unwittingly charged these fees. To compound these issues, the process of reversing and reissuing payments via a preferred method is often so tedious and time-consuming that physicians simply cannot afford to spend the time to request corrections. The lack of transparency, in part, results from coercive business practices, with most plans and vendors defaulting to fee-based transactions and forcing physician practices to "opt out" of VCCs or fee-based EFT. We have heard from many practices that this "opt out" process can be extremely time-consuming and administratively burdensome. Taken together, these negative factors have led to suboptimal EFT utilization: the most recently available data from the 2024 CAQH Index shows EFT adoption at only 77 percent, compared with 98 percent for electronic claims.

To address these concerns with HHS and CMS and ensure that EFT standard transactions reap their intended benefits, the AMA has recommended that the agencies vigorously enforce existing guidance regarding health plans' use of VCC or EFT fee-based programs.

The AMA has also urged the agencies to issue additional guidance that will protect physicians from unfair business practices by:

- Clarifying that health plans and their contracted vendors cannot require a physician to agree to additional services and/or fees as a condition of receiving payments using the EFT standard;
- Requiring health plans and their vendors to prominently offer an ACH EFT option with no associated fees;

- Requiring health plans and their vendors to offer VCC or fee-based EFT strictly using an opt-in model, under which physicians receive clear and full information about the additional costs involved and proactively agree to using this method before any payments are issued; and
- Requiring all health plans and their vendors to contact physicians in advance of any expiration of EFT enrollment and facilitate swift reenrollment vs. automatically defaulting to VCC or fee-based EFT payments.

Ultimately, AMA wants the agencies to support the EFT regulation's underlying goals and create the much-needed transparency that physicians and other providers need to make informed, independent choices about the appropriate payment method for their practices.

Legislative Action

In addition, the AMA is proceeding with advocacy before Congress to act on behalf of physicians. The AMA helped introduce the "No Fees for EFTs Act" (H.R. 6487) introduced by Representative Greg Murphy, MD (R-NC) in November 2023 and companion legislation in the Senate (S. 3805), led by Senators Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA). These bills, which received bipartisan support, would prohibit health plans from "imposing fees on providers for EFTs and health care payment and remittance advice transactions." During that Congress, AMA staff worked with Congressional champions to address proposed legislative language changes and to preserve provisions aligned with AMA policy objectives. Although negotiations ultimately stalled and the legislation was not advanced before the close of the 118th Congress, the issue remains a priority. The AMA continues to work with Congressional champions to reintroduce the "No Fees for EFTs Act" this Congress. Progress was slowed by staff transitions within key Congressional offices; however, AMA staff have met with the bill sponsors and their teams and understand that the legislation remains a priority. The AMA anticipates continued engagement aimed at securing reintroduction in the near term.

State legislatures are also increasingly examining the use of VCCs by health plans and their contracted vendors. The AMA has supported state-level efforts consistent with existing AMA policy and has worked with state medical societies and coalition partners to advance legislation that promotes transparency, voluntary physician choice, and access to no-fee EFT options. Several states, including Alabama, Arizona, Georgia, and New York, have enacted legislation designed to increase transparency in electronic payment practices, clarify physician choice, and limit the imposition of excessive transaction fees. These laws generally require clearer disclosure of payment methods and associated fees, prohibit default enrollment into VCC programs without affirmative consent, and, in some cases, restrict the ability of plans or vendors to condition participation on acceptance of fee-based payment mechanisms. Going forward, the AMA will continue to collaborate with interested state medical associations, monitor emerging legislative proposals, and support state initiatives that address coercive payment practices, enhance disclosure requirements, and reinforce physicians' right to timely, no-fee electronic payment options.

State efforts reflect growing recognition that VCC practices can erode negotiated payment rates and impose avoidable administrative burden on physician practices. While statutory approaches vary by state, the common themes include strengthening opt-in protections, enhancing transparency around fees and incentives, and reinforcing the availability of lower-cost ACH EFT options. The AMA continues to monitor these developments and support state medical associations as they pursue reforms consistent with AMA policy.

ACTION ITEMS

The Board of Trustees recommends that, consistent with Resolution 819 and existing AMA policy, the AMA pursue the following implementation priorities over the coming year:

1. The AMA will engagement with HHS and CMS to press for stronger enforcement of existing HIPAA Administrative Simplification requirements related to electronic payment standards.
2. The AMA will request that CMS issue clarifying guidance affirming physicians' right to receive timely ACH EFT payments without being required to purchase additional services or incur add-on processing fees and reinforcing that nonstandard payment options must not undermine the intent of the EFT standard.
3. The AMA will work with congressional champions to reintroduce and advance the "No Fees for EFTs Act" in the 119th Congress
4. The AMA will support state medical societies in state legislative and regulatory efforts that increase transparency around VCC use, limit coercive opt-out structures, or restrict excessive electronic payment fees, consistent with existing AMA policy.
5. The AMA will communicate with physicians regarding the financial implications of VCC and fee-based EFT programs and reinforce available information about compliant ACH EFT options and physician rights under existing standards.

CONCLUSION

The financial and administrative burdens associated with VCC payments and fee-based EFT programs remain significant and persistent. Despite longstanding statutory standards under HIPAA Administrative Simplification and the Affordable Care Act's EFT requirements, many health plans and their vendors continue to default physicians into payment methods that impose avoidable fees, reduce negotiated reimbursement, and create unnecessary administrative burden. The Change Healthcare cyberattack further exposed vulnerabilities in electronic payment systems and highlighted the consequences of inadequate enforcement and oversight.

Through regulatory advocacy, legislative engagement, and state-level collaboration, the AMA has continued to advance policies designed to protect physician autonomy, support transparency, and secure access to timely, no-fee electronic payments. However, relief will require stronger enforcement by CMS, clear regulatory guidance, and Congressional action to eliminate improper transaction fees. The Board of Trustees will continue to pursue a coordinated legislative and regulatory strategy consistent with Policies H-190.955, D-190.968, and D-190.970. The recommendations below also include rescission of Policy D-190.965, as its reporting directive has been fulfilled through submission of this report.

RECOMMENDATIONS

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

1. That Policy D-190.965 be amended to read as follows:

   Our American Medical Association report at the Annual 202~~6~~7 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Update HOD Policy)

2. That our AMA reaffirm Policies H-190.955, “Virtual Credit Card Payments;” D-190.968, “Amend Virtual Credit Card and Electronic Funds Transfer Fee;” and D-190.970, “CMS Administrative Requirements.” (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REPORT 28 OF THE BOARD OF TRUSTEES (A-26)
Accountability in the Use of Augmented Intelligence for Prior Authorization
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted amended Resolution 823, which strengthened Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," and directed the Board of Trustees to report back to the 2026 Annual Meeting on actions taken. This report responds to that directive while also recognizing that more recent legislative and regulatory developments may not be fully reflected due to report preparation timelines.

The rapid expansion of insurer use of augmented intelligence (AI) in prior authorization (PA) and claims review presents significant risks to patient access, clinical autonomy, and administrative burden. When deployed without comprehensive oversight, transparency, and clinician involvement, AI-enabled tools can accelerate denials, undermine individualized patient assessment, and scale opaque decision-making processes that are difficult for patients and physicians to challenge. Testimony in support of Resolution 823 emphasized that clear guardrails are necessary for AI to enhance administrative efficiency without replacing independent clinical judgment or creating new barriers to medically necessary care.

Consistent with Policy D-480.956 and related policy H-480.931, the AMA has advanced a comprehensive advocacy strategy at the federal and state levels. The AMA has supported federal legislation, including the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514/S. 1816), which would require Medicare Advantage plans to publicly report their use of AI and related technologies in PA decisions. The AMA has also engaged Congress, the Office of Science and Technology Policy, and the Centers for Medicare & Medicaid Services to promote requirements that insurer AI use be grounded in evidence-based clinical guidelines; that adverse determinations informed by AI be reviewed by qualified, specialty-appropriate clinicians who are not incentivized to deny coverage for care; and that patients and physicians have access to the criteria and information underlying coverage decisions.

At the state level, the AMA has supported enactment of guardrails limiting insurer reliance of AI in utilization management, including requirements for individualized clinical review, audit authority, public reporting, and prohibitions on automated systems serving as the sole basis for medical necessity denials. In parallel, the AMA has worked within national AI technical standards processes to improve transparency regarding whether human review occurred and to facilitate identification of reviewer specialty.

The AMA has also emphasized safeguards to protect continuity of care, including requiring direct clinician review of patient records before any AI-flagged denial of previously approved medications, strengthening appeals processes, and advancing protections against algorithmic discrimination to ensure equitable access to care.

While progress has been made, insurer use of AI in coverage determinations continues to expand, often without sufficient visibility or enforceable safeguards. The AMA will continue to advocate for legislative and regulatory reforms that ensure AI-supported PA processes remain transparent, clinically grounded, equitable, and accountable to qualified physicians. This ongoing work advances the goals of Policy D-480.956 and reinforces the AMA's leadership in protecting patients and physicians as AI becomes more deeply embedded in health care coverage decisions.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 28-A-26

Subject: Accountability in the Use of Augmented Intelligence for Prior Authorization (Res. 823-I-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting, the House of Delegates (HOD) adopted Resolution 823, "Accountability in the Use of Augmented Intelligence for Prior Authorization," which modified existing AMA Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization" to read as follows:

1. Our American Medical Association will work with stakeholders to advocate for legislative and/or regulatory action for greater regulatory oversight related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:
    a. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
    b. includes reviews by physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
    c. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
    d. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
    e. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.
2. Our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates.

Resolution 823 amended Policy D-480.956 to more clearly articulate that insurer use of augmented intelligence in claims review and PA must be subject to meaningful regulatory oversight and grounded in a thorough and fair process. As amended, the policy specifies that such processes must be based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed literature; include review by physicians and other health care professionals who are not incentivized to deny care and who have expertise in the service under review; provide transparency and accountability for all medical service denials; require direct review of patient records by a qualified clinician, including for medications previously approved by payers; and include robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

The AMA is actively pursuing legislative and regulatory strategies to advance these guardrails at both the federal and state levels. This report outlines the actions taken before and after adoption of Resolution 823-I-25 to implement the amended policy and fulfill the reporting requirement.

AMA POLICY

Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization" (See above)

Policy H-480.931, "Assessing the Intersection Between AI and Health Care"

(9) Payor Use of Augmented Intelligence and Automated Decision-Making Systems

a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician: (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized, and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

DISCUSSION

The AMA's strategy to address the growing use of AI by payers in claims review and PA includes strong advocacy efforts to pursue legislative and regulatory solutions that ensure meaningful oversight of these tools and the processes surrounding them. Specifically, we support standards requiring that AI-informed determinations be grounded in current, evidence-based clinical guidelines; incorporate independent review by qualified clinicians with relevant expertise; and provide clear transparency, accountability, and robust appeals protections. Together, these reforms are intended to safeguard patient access to medically necessary care and prevent inappropriate, biased, or financially driven denials. The following section includes the steps taken between now and the previous meeting directed at this issue:

Insurer use of AI should be based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.

The AMA is establishing and advancing a clear set of federal guardrails for insurer use of AI in coverage decisions. AI-driven automation is increasingly being used to accelerate denials and coverage limitations, with significant downstream burdens for physicians and clinically harmful delays for patients. AMA policy and congressional facing advocacy emphasize that, absent stronger guardrails, AI-enabled processes can undermine individualized patient assessment and contribute to inappropriate denials that patients and physicians struggle to understand and overturn.
Consistent with the resolution's core requirement, AMA policy states that insurer AI used to determine coverage limits, make claim determinations, or engage in benefit design must be based on easily accessible, evidence-based clinical guidelines (not proprietary payer criteria) and disclosed to patients and physicians in an understandable way. The AMA is reinforcing this position in congressional advocacy, urging policymakers to require public reporting and disclosure of AI use and to ensure that the basis for coverage decisions is transparent and clinically grounded rather than opaque or proprietary. In addition, the AMA supports state-based advocacy efforts to advance these guardrails and collaborates with state medical associations and patient advocacy organizations to promote transparency, clinician oversight, and equitable access to care. The AMA has engaged with national organizations, including the National Association of Insurance Commissioners (NAIC), on broader PA and UM reforms that intersect with oversight of automated decision-making tools.

The AMA is advocating that insurer AI coverage criteria must be accountable to the medical evidence base, requiring payers to identify and cite peer-reviewed studies evaluating system accuracy and the validity of predictions, and to provide affected patients and physicians access to the relevant coverage criteria, results, and clinical guidelines used in the determination. Despite these established guardrails and repeated engagement with policymakers, including communication to the Senate Committee on Health, Education, Labor and Pensions and the Office of Science and Technology Policy, AMA's advocacy underscores that insurer noncompliance and continued opaque AI-driven denials necessitate stronger oversight expectations to ensure AI is used only in ways that reduce administrative burden without restricting medically necessary care.

Insurer AI use must include reviews by physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.

The AMA advocates that insurer use of AI in coverage determinations must not substitute for independent clinical judgment, particularly given the real-world pattern of AI enabled automation being used to accelerate denials and compound administrative burden and delays in care. The AMA has therefore advanced guardrails that center on two complementary requirements: (1) case level clinician review that is clinically meaningful and specialty appropriate before an adverse determination is finalized; and (2)

structural protections to reduce conflicts of interest and ensure decisions reflect independent medical judgment rather than denial-driven incentives.

At the case level, AMA policy states that when AI is used for payer coverage limits, claim determinations, or benefit design, payers should be required to ensure that decisions are reviewed by physicians and other health care professionals who are not incentivized to deny care and who have expertise for the service under review, a standard that directly aligns with this resolution's requirement for specialty appropriate clinician oversight. With the AMA's support, California enacted Senate Bill 1120 (2024 Cal. Stat. ch. 879 (S.B. 1120)) in 2024 which mandates that AI tools used for utilization review or UM decisions comply with a variety of requirements, including that the tool: does not supplant individualized health care provider decision-making; does not directly or indirectly discriminate; be fairly and equitably applied; and be open to audit for compliance. California's new law also specifies that an AI tool cannot deny, delay, or modify health care services based on medical necessity and that such decisions shall only be made by a physician or health care professional competent to evaluate the specific clinical issues involved. At the federal level, Centers for Medicare and Medicaid Services (CMS) is testing technology-enabled review processes through the Wasteful and Inappropriate Service Reduction (WISeR) model, developed by the Center for Medicare & Medicaid Innovation. The model incorporates the use of advanced analytics, including AI-supported tools, to assist in reviewing certain services within Medicare fee-for-service. CMS has indicated that the model will include safeguards such as clinician review of determinations and documentation regarding the role of AI tools in coverage decisions. The AMA is closely monitoring implementation of the model and engaging CMS to promote transparency, accountability, meaningful physician oversight, robust guardrails, streamlined administrative processes, patient access to timely care, and greater use of evidence-based clinical guidelines consistent with AMA policy governing the use of AI in coverage determinations.

The AMA is reinforcing the need for meaningful clinician review in congressional advocacy by pressing for requirements that adverse AI recommendations be subject to physician review before finalization and that coverage decisions be grounded in independent clinical judgment rather than opaque automated workflows. To facilitate and track human review of payer AI use, the AMA was successful in modifying national AI technical standards that indicate whether a human was involved in the coverage decisions and an optional code to allow for sending the reviewer's specialty information.

At the structural level, the AMA is emphasizing that insurer review processes and UM governance must be designed to prevent conflicts of interest from shaping clinical outcomes. In its 2026 Medicare Advantage comment letter, the AMA urged strengthening UM committee composition and independence, recommending that these committees include practicing physicians, and that independent physician participation be increased to a majority to ensure that coverage criteria and adverse determinations are informed by practicing clinician expertise and insulated from incentives that could compromise independent clinical judgment.

Despite these established guardrails, AMA's ongoing advocacy reflects that insurer AI use continues to undermine independent clinical review in practice, reinforcing the need for stronger oversight expectations to ensure that AI-supported coverage decisions remain accountable to qualified, specialty-appropriate clinicians and do not become a vehicle for inappropriate denials and avoidable care delays.

Insurers provide transparency and accountability over the use of AI for all medical service denials, to include a direct review of patient records by a qualified clinician.

The AMA advocates that insurer use of AI-driven automated decision-making in coverage determinations must be subject to clear transparency and real accountability. Opaque AI-enabled denials can scale quickly, exacerbate PA burdens, and create avoidable delays in medically necessary care. AMA's policy

and congressional-facing advocacy underscore that patients and physicians must be informed and empowered to question AI-supported coverage decisions, and that stronger oversight expectations are warranted when insurers use these systems for coverage, claims determinations, and benefit design.

At the point of denial, the AMA is advancing clear transparency expectations. AMA policy calls for insurer use of automated decision-making systems to be publicly reported and disclosed to patients and physicians in an easy-to-understand manner, including clear communication that AI was used when it was part of the denial decision-making. The AMA further specifies that individuals impacted by an insurer's automated decision-making system, including patients and their physicians, must have access to all relevant information underpinning the coverage determination, including the coverage criteria, the results that led to the determination, and the clinical guidelines used. In parallel, the AMA warns that a core failure mode of insurer automation is the absence of individualized review, where denials are made without patient specific assessment and, in some cases, without opening or reviewing the patient's medical record, underscoring why transparency must be paired with meaningful clinical accountability whenever AI is used to recommend or trigger a denial.

On accountability, the AMA is urging routine auditing and public reporting to detect and correct harmful patterns. AMA policy calls for insurers using automated decision-making systems to conduct regular system audits to ensure AI use is not increasing overall or disparate denials/coverage limits or otherwise reducing access to care, and to make approval, denial, and appeal rate statistics publicly available in a readily accessible format with patient population demographics to contextualize equity implications. Notably, the AMA has vigorously advocated for passage of H.R. 3514/S. 1816, the "Improving Seniors' Timely Access to Care Act of 2025," which would make important reforms in Medicare Advantage PA programs. The bill would require Medicare Advantage plans to publicly disclose the percentage and number of PA requests that were denied in the previous plan year "through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary," as well as disclose and describe the technology utilized in evaluating PA requests. In December 2025, the AMA led over 120 physician organizations in a sign-on letter to congressional leadership expressing long-standing support for this bill and the improved transparency it would bring to Medicare Advantage PA programs, including this critical public reporting of plans' use of AI in coverage determinations.

AMA efforts have supported several states that have now enacted laws that establish guardrails that directly constrain insurer use of AI and automated tools in UM and adverse determinations. In Maryland (H.B. 820), plans must report quarterly to the Insurance Commissioner whether an "artificial intelligence, algorithm, or other software tool" was used in an adverse decision, and they must ensure that any such tool is applied to the patient's individual medical history and clinical circumstances, does not replace provider judgment, avoids discrimination, is regularly evaluated for accuracy and reliability, and does not use patient data beyond its stated purpose. In Arizona (H.B. 2175), a claim denial based on medical necessity requires individual review by the plan's medical director, exercising independent medical judgment and not relying solely on recommendations from other sources. Nebraska (LB 77) bars an AI algorithm from being the sole basis for denying, delaying, or modifying services based on medical necessity, and requires disclosure when AI is used in UM. Texas (S.B. 815) prohibits the use of automated decision systems to make adverse determinations, while allowing such tools for administrative support or fraud detection, and clarifies the Insurance Commissioner's authority to audit and inspect these tools.

The NAIC Big Data and Artificial Intelligence Working Group has made insurer use of AI a sustained regulatory priority and is encouraging state insurance regulators to apply consistent governance expectations. In December 2023, NAIC issued a model bulletin for states to adopt, reminding insurers that AI-enabled decisions affecting consumers remain subject to existing state laws (including unfair trade

practice and other consumer protection requirements), and outlining baseline governance expectations and the types of information regulators may request during examinations or investigations. To date, 25 states have adopted the bulletin. NAIC has also released data describing how health plans report using AI across functions such as contracting, fraud detection, pricing, plan design, risk adjustment, risk management, marketing, data processing, and claims determinations—information that can inform ongoing evaluation of state proposals addressing payer use of clinical algorithms and AI in medical necessity decision-making. AMA contributed suggestions for the NAIC survey of health insurers inquiring how they are using AI, including in PA and other UM. AMA provided significant input on the recently released NAIC PA white paper. AMA shared perspectives on and has been monitoring implementation of the NAIC model AI bulletin that covers all insurance.

At its 2025 Summer Meeting, the National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee considered draft legislation on insurers' use of AI and specifically in the claims process. The Committee heard from stakeholders including the AMA, who supported guardrails around health plans' use of AI in the claims determination process, while representatives from the insurance industry discouraged the committee from developing any model, calling it premature. It seems likely that the committee will continue to discuss potential model legislation at upcoming meetings.

The AMA's broader advocacy also emphasizes that current protections remain insufficient and that AI-driven denials continue to occur without adequate visibility and individualized review, reinforcing the need for stronger oversight expectations to ensure AI improves administrative efficiency without becoming a mechanism for inappropriate denials and delayed care.

Insurers require direct review of the patient record by a qualified clinician of all medications flagged for denial by AI platforms that were previously approved by payers.

The AMA is advancing clear guardrails across its policy and federal advocacy to ensure that insurer use of AI does not create new pathways to interrupt medically necessary medications that have already been approved and initiated. In the AMA's view, AI may be used to flag cases for review, but it must never be used to automatically deny, terminate, or disrupt a previously approved medication, particularly in continuation or renewal scenarios where patients are clinically stable and interruptions can cause harm and compound administrative burden. The AMA has consistently emphasized that PA related disruptions already undermine continuity of care, and that deploying AI in these workflows without strong safeguards risks scaling inappropriate denials and worsening care delays.

AMA policy requires that any automated recommendation indicating a denial or limitation of care be automatically referred for physician review prior to any final determination, with the reviewer possessing appropriate licensure and specialty alignment, and with a meaningful opportunity for clinical discussion before an adverse decision is issued. This "AI flags, clinicians decide" construct is the factual backbone for requiring direct review of the patient record by a qualified clinician before any AI-triggered medication denial is finalized. The AMA is advancing the same principle in congressional-facing advocacy, warning that automated decision-making must not replace individualized assessment of patient specific needs, must allow flexibility to override automated outputs, and must not be based on generalized "similar patient" logic.

The AMA is taking these guardrails directly to federal policymakers. In engagement with Congress, the AMA is urging stronger transparency and oversight when payers use automated decision-making for coverage and benefit determinations, emphasizing that patients and physicians must be empowered to question automated decisions and that these systems must not override clinical judgment. In related congressional advocacy, the AMA is highlighting patterns showing inadequate individualized review and

is calling for guardrails that include physician oversight for adverse AI-driven determinations and a pathway to ensure the treating physician can meaningfully engage before a denial is finalized.

In parallel, the AMA is pressing CMS to ensure coverage criteria and medical necessity determinations, particularly for prescription drugs, are grounded in sound clinical validity and transparency, noting the importance of protections for beneficiaries who rely on medications to maintain health and wellbeing. The AMA is supporting prohibitions on reopening favorable medical necessity decisions absent good cause, reinforcing the core reliance interest that patients and physicians should be able to depend on prior approvals without fear of subsequent reversal, an essential principle when AI is introduced into renewal/continuation workflows.

Insurers must provide robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

The AMA has consistently advocated that insurer use of AI in UM must be paired with practical, patient-centered safeguards. When automated systems accelerate denials or restrict coverage without meaningful checks, patients experience harmful delays and physicians face escalating administrative burden. The AMA is emphasizing that robust, workable appeals processes are not optional; they are a necessary backstop to ensure that inappropriate or erroneous AI-influenced denials can be promptly corrected and that patients are not deprived of medically necessary care.

Consistent with this resolution, AMA policy calls for insurer automated decision-making that recommends a denial or limitation to be referred for physician review before a final determination, and for that same clinician-centered safeguard to apply across the review continuum, including at the appeals level. The AMA's advocacy highlights that appeals processes frequently function poorly in practice, even when denials are inappropriate: available evidence shows that only a small fraction of Medicare Advantage PA denials are appealed (11.5 percent in 2024), yet a substantial share of appealed denials are overturned (80.7 percent in 2024), underscoring that many patients may forgo medically necessary care because the appeals pathway is too burdensome, too slow, or too opaque to navigate. This pattern reinforces why appeals must be designed to work in real world clinical settings: timely, accessible, and capable of meaningful review by qualified clinicians.

In addition, the AMA is urging that safeguards against algorithmic discrimination be built into insurer AI use so that automated decision-making does not systematically disadvantage certain patients or reduce equitable access to care. AMA policy calls for payers to demonstrate that automated systems do not discriminate and to implement protections to mitigate bias that could affect coverage determinations.

CONCLUSION

The AMA has taken substantial and coordinated action across federal and state advocacy channels to advance oversight, transparency, and accountability in the use of AI in PA and coverage determinations. Through comment letters, congressional engagement, technical standards development, support of federal legislation, and state-level policy advancement, the AMA has reinforced the core guardrails articulated in policy D-480.956 and H-480.931.

Specifically, the AMA has advanced requirements that insurer AI use be grounded in evidence-based clinical guidelines; that adverse determinations informed by AI be subject to review by qualified, specialty-appropriate clinicians who are not incentivized to deny care; that patients and physicians receive clear disclosure when AI is used and have access to the criteria and data underlying determinations; that previously approved medications not be disrupted without individualized clinician review; and that appeals processes and anti-discrimination safeguards function effectively in practice.

Despite these efforts, insurer use of AI in UM continues to expand in ways that risk accelerating inappropriate denials, increasing administrative burden, and delaying medically necessary care. The AMA's advocacy therefore remains ongoing and focused on strengthening enforceable guardrails, improving transparency, and ensuring that AI enhances administrative efficiency without supplanting individualized clinical judgment or compromising patient access.

The Board of Trustees will continue to monitor legislative, regulatory, and market developments related to payer use of AI and will report back to the House of Delegates as appropriate.

RECOMMENDATIONS

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

1. Our American Medical Association (AMA) will:
    1) Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature.
    2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to review by qualified, specialty-appropriate clinicians who are not incentivized to deny coverage for care, and to ensure that automated systems do not supplant individualized clinical judgment.
    3) Support and seek advancement of federal legislation to promote transparency in Medicare Advantage prior authorization programs, including public reporting of AI and automated decision-making use.
    4) Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations.
    5) Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI-generated recommendations without direct review of the patient record by a qualified clinician.
    6) Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity denials and promote clinician oversight, audit authority, and protections against algorithmic discrimination.
    7) Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty. (Directive to Take Action)

2. That item two of Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Fiscal Note: Less than $500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-26)

Introduced by: Oklahoma, Mississippi

Subject: Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety

Referred to: Reference Committee B

Whereas, newer kratom products concentrated with 7-hydroxymitragynine (7-OH), a potent opioid-like compound far stronger than traditional kratom leaf, pose heightened risks of addiction, overdose, and other harms, prompting regulatory concerns due to threats to American consumers[1,2]; and

Whereas, these 7-OH products are often marketed in child-appealing forms such as flavored shapes and brightly colored packaging, contributing to rising pediatric exposures reported to U.S. poison centers and increased access by minors[3,4]; and

Whereas, national survey data from the Substance Abuse and Mental Health Services Administration indicate that tens of thousands of U.S. adolescents aged 12–17 have used kratom, based on estimated prevalence rates[3,5]; and

Whereas, published studies report that kratom is used for perceived stimulant and mood-enhancing effects, including for focus, studying, and recreational purposes[3,5]; and

Whereas, data from U.S. poison control centers demonstrate that approximately 10% of reported kratom exposures involve individuals under 20 years of age, including children under 13[3]; and

Whereas, high-potency and concentrated kratom products, including those containing 7-hydroxymitragynine (7-OH), may deliver unpredictable and excessive doses, increasing the risk of toxicity[3 5]; and

Whereas, reported outcomes from kratom exposures include moderate to severe adverse effects requiring medical evaluation and hospitalization, with documented risks of dependence and substance use disorder[3 5]; and

Whereas, cases of neonatal abstinence syndrome mimicking opioid withdrawal have been documented in infants born to mothers using kratom chronically during pregnancy, underscoring risks to the youngest and most vulnerable children[6]; and

Whereas, public health officials and physicians warn that high-potency kratom products are expanding rapidly in commercial markets and disproportionately appealing to youth, while no adequate and well-controlled clinical trials demonstrate kratom’s safety or efficacy for any medical use, leading medical organizations to advise clinicians to counsel patients against use[2,7]; and

Whereas, the American Medical Association (AMA) recommends that kratom be regulated by the Food and Drug Administration, that its safety and efficacy be established through rigorous clinical trials prior to marketing or over-the-counter sales, and that unregulated kratom products constitute a serious public health concern (AMA Policy H-95.903)[8]; therefore be it

RESOLVED, that our American Medical Association our AMA amend policy H-95.903 by addition, Regulate Kratom and Ban Over-The-Counter Sales, to read:

1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition;

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA adopt a policy to ban the sale, distribution, or marketing of 7-hydroxymitragynine (7-OH) concentrated kratom products (New HOD Policy); and be it further

RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, and support research into pediatric exposures and optimal regulatory frameworks. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/7/26

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2. Eggleston W, Stoppacher R, Suen K, Marraffa JM, Nelson LS. Kratom use and toxicities in the United States. Pharmacotherapy. 2019;39(7):775-777. doi:10.1002/phar.2280 Kratom Use and Toxicities in the United States
Post S, Spiller HA, Chounthirath T, Smith GA. Kratom exposures reported to United States poison control centers: 2011-2017. Clin Toxicol (Phila). 2019;57(10):847-854. doi:10.1080/15563650.2019.1569236 Kratom exposures reported to United States poison control centers: 2011-2017: Clinical Toxicology: Vol 57 , No 10 - Get Access
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7. American Medical Association House of Delegates. Policy H-95.903: Kratom. American Medical Association; reaffirmed 2023. H-95.903 Regulate Kratom and Ban Over-The-Counter Sales | AMA

RELEVANT AMA POLICY

Regulate Kratom and Ban Over-The-Counter Sales H-95.903

1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-26)

Introduced by: Florida, Texas, Oklahoma

Subject: Using and Defining “Unsupervised Practice of Medicine”

Referred to: Reference Committee B

Whereas, the American Association of Nurse Practitioners (AANP) is advocating for “Full practice authority (FPA)” or “Independent practice” to practice without physician supervision or a collaborative practice agreement; and

Whereas, FPA is not a legal or regulatory category but a political term used by nursing organizations to describe the removal of physician supervision; and

Whereas, scope-of-practice laws vary widely, and no state grants complete authority equivalent to physician licensure; and

Whereas, the AMA believes non-physicians should be supervised under the physician led care team model with direct on-site supervision of non-physician practitioners as the gold standard; and

Whereas, having a standard terminology would help define our goal of supervised practice in all medical settings; and

Whereas, nurse practitioners assert that they practice advanced nursing rather than the practice of medicine; yet their day-to-day activities—diagnosing disease, ordering and interpreting diagnostic tests, performing medical procedures, and prescribing medications, including controlled substances—are universally recognized as core components of the practice of medicine as defined in state medical practice acts; and

Whereas, the practice of medicine is legally distinct from the practice of nursing, with medicine defined as the independent evaluation and treatment of human illness, injury, and disease while nursing is defined as the promotion of health, the prevention of illness, and the management of human responses to health problems within a nursing framework; and

Whereas, by performing medical diagnostic and therapeutic activities outside the physician-led model, nurse practitioners functionally engage in the practice of medicine while holding a nursing license, creating regulatory inconsistency and patient confusion regarding the level of training associated with these medical acts; therefore be it

RESOLVED, that our American Medical Association use the term “Unsupervised Practice of Medicine” (UPM) when describing statutory or regulatory efforts that allow nonphysician practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that physician-led, team-based care with appropriate physician supervision remains the gold standard for patient safety and quality care (New HOD Policy); and be it further

RESOLVED, that our AMA incorporate the term “Unsupervised Practice of Medicine” in its advocacy materials, public communications, testimony, and educational resources, where appropriate, to clarify the distinction between physician licensure and nonphysician scope expansion (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for truth in advertising, transparency in professional identification, and clear communication to patients regarding differences in education, training, and licensure between physicians and nonphysician practitioners. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-26)

Introduced by: Florida, Texas, Oklahoma

Subject: Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice

Referred to: Reference Committee B

Whereas, the American Medical Association has longstanding policy supporting physician-led, team-based care as the model most consistent with patient safety and quality; and

Whereas, 27 states currently permit unsupervised practice of medicine (UPM) by nurse practitioners, and some states have allowed UPM for decades; and

Whereas, many scope-of-practice expansions have occurred without prospective, randomized, or methodologically rigorous comparative studies evaluating patient outcomes when physician supervision is removed; and

Whereas, existing studies frequently cited in support of expanded scope of practice often examine care delivered within physician-led teams, protocol-based environments, or limited patient populations, rather than independent clinical decision-making; and

Whereas, objective, high-quality evidence is essential to inform legislators, regulators, physicians, and patients regarding the safety, quality, and appropriate role of unsupervised NP practice; therefore be it

RESOLVED, that our American Medical Association advocate for and support funding of independent, academically rigorous studies comparing patient outcomes between unsupervised nurse practitioner care and physician-led team-based care, including measures of patient safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-reviewed literature. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

REFERENCES

1. Bernard R. Nonphysician Unsupervised Practice of Medicine: Examining the Evidence. Mo Med. 2025 Sep-Oct;122(5):351-356. PMID: 41132456; PMCID: PMC12543343.

RELEVANT AMA POLICY

To Study the Cost and Quality Impact of Non-Physician Provider Employment in the United States of America D-200.973
Our American Medical Association encourages and supports studies to determine the cost and quality impact of non-physician unsupervised practice on all patients.
Our AMA will develop model state legislation that opposes enactment of legislation and supports reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician.

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982
1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.
2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-26)

Introduced by: Florida, New York, Texas, Oklahoma

Subject: D-400.982 Revision

Referred to: Reference Committee B

Whereas, Medicare physician fee schedule payment reform is a top priority of the American medical Association and policy D-400.982 was passed in 2024; and

Whereas, the House of Delegates should received regular updates regarding the AMA's progress on this issue; therefore be it

RESOLVED, that our American Medical Association reaffirm D-400.982:

1. Our American medical Association will increase media awareness around the 2024 AMA Annual Meeting about the need for Medicare payment reform eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up it's public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare payment reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of current inadequacies of Medicare payments.

(Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA will report back quarterly to the House of Delegates via open forum on these Medicare Payment Reform initiatives. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

REFERENCES

1. D-400.982 in the AMA Policy Compendium

RELEVANT AMA POLICY

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Citation: BOT Rep. 12, A-24; Reaffirmed: Res. 220, I-24;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-26)

Introduced by: Florida, New York, Texas, Oklahoma

Subject: Repeal of the Merit-Based Incentive Payment System (MIPS)

Referred to: Reference Committee B

Whereas, the Merit-Based Incentive Payment System (MIPS) has disproportionately harmed rural physician practices[1], clinicians serving minority and socioeconomically disadvantaged populations[2]. CMS data shows that rural clinicians are 30–40% more likely to receive negative or neutral payment adjustments1. Clinicians treating high-social-risk patients score up to 20 points lower on average, resulting in higher penalty rates[2]; and

Whereas, private, small, and solo practices face significant structural disadvantages under MIPS, with Health Affairs estimating that such practices spend $12,800–$40,000 per clinician annually on MIPS participation and 84% reporting “substantial or extreme” burden—threatening practice viability and accelerating consolidation[3]; and

Whereas, MIPS has not demonstrated meaningful improvement in patient outcomes or reductions in healthcare cost, with the Medicare Payment Advisory Commission (MedPAC) concluding in its 2022 Report to Congress that MIPS is “fundamentally flawed,” “not evidence-based,” and “unlikely to improve quality or efficiency,” and with studies showing MIPS scores are not correlated with validated outcome measures[4]; and

Whereas, physicians spend 200+ hours per year on MIPS-related documentation reducing clinical availability and continuity of care[5]; and

Whereas, MIPS contributes significantly to physician burnout, with the 2023 AMA/Stanford/Press Ganey burnout study identifying federal reporting programs as a top regulatory driver; physicians subjected to high administrative burden are 2.6 times more likely to report intent to leave practice within two years, threatening workforce stability[6]; and

Whereas, MIPS-related administrative costs and penalties accelerate early physician retirement, particularly among older physicians and those in independent practice, with physicians over age 60 being twice as likely to retire early under high regulatory load, while nearly one in five independent physicians report considering closing or selling their practice due to reporting mandates—exacerbating the projected national shortfall of over 100,000 physicians by 2034[7]; and

Whereas, HOD Policy D-400.982, asks our AMA to advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments; therefore be it

RESOLVED, that our American Medical Association support full repeal of the Merit-Based Incentive Payment System (MIPS) (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for immediate administrative relief in MIPS, including expanded low-volume and hardship exemptions for rural and small practices,

shortened/streamlined reporting requirements, and reduction of reporting complexity until MIPS is repealed. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

RELEVANT AMA POLICY

400.982 AMA Efforts on Medicare Payment Reform D-400.982
Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.
BOT Rep. 12, A-24Reaffirmed: Res. 220, I-24

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

MIPS and MACRA Exemption H-390.838
Our American Medical Association will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices. Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21

Merit-Based Incentive Programs H-478.986
Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.
Res. 213, A-16

Preserving Patient Access to Small Practices Under MACRA D-390.949
1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.
Res. 243, A-16 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20

Reducing MIPS Reporting Burden D-395.999
Our American Medical Association will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician’s choosing) within the calendar year.
Res. 236, A-18 Reaffirmation: A-19 Reaffirmed: BOT Rep. 13, I-20 Reaffirmed: Res. 220, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-26)

Introduced by: American Association of Clinical Urologists

Subject: Overall Hospital Quality Star Ratings / CMS Star Ratings

Referred to: Reference Committee B

Whereas, the Overall Hospital Quality Star Rating (CMS Star Rating) summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital; and

Whereas, the Overall Star Rating includes 5 measure groups: *Mortality, Safety of Care, Readmission, Patient Experience, and Timely & Effective Care*; and

Whereas, according to our AMA, the most effective way to maximize the complementary skill sets of all health care professionals is to work as part of a physician-led team; and

Whereas, according to our AMA, physician expertise is widely recognized as integral to quality medical care in the United States. With 7 years or more of postgraduate education and at least 10,000 hours of clinical experience through training, physicians are the natural leaders in the overall delivery of health care; and

Whereas, patients are asked to qualitatively assess hospital quality via patient surveys; and

Whereas, physicians have the unique position as leaders of the health care team to qualitatively assess how hospitals embrace quality in the delivery of patient care; therefore be it

RESOLVED, that our American Medical Association advocate to CMS that the Overall Hospital Quality Star Ratings (CMS Star Ratings) include a 6th measured group defined as *Physician Experience* which would include those physicians who have membership on the hospital medical staff. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-26)

Introduced by: American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Subject: Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program

Referred to: Reference Committee B

Whereas, national hospital data show that in 2022, 52.4% of rural hospitals did not offer obstetric care, reflecting a sustained decline in hospital-based obstetric services; and analyses of rural labor-and-delivery service lines report continued closures since 2020 associated with financial losses and workforce constraints;[1, 2] and

Whereas, rural hospital financial viability and emergency transfer capacity may be affected by workforce migration, liability exposure, and service line limitations; and

Whereas, 64% of foreign-trained physicians practice in medically underserved areas or health professions shortage areas[3]; and

Whereas, nearly 21 million Americans live in areas where foreign-trained physicians account for at least half of physicians[4]; and

Whereas, changes in systems granting J-1 Visas for physicians and other federal administrative or regulatory disruptions can reduce or delay the potential physician workforce in rural areas; and

Whereas, The Conrad 30 Waiver Program (also known as the Conrad State 30 Program) is a federal initiative in the United States designed to address doctor shortages in underserved communities;[5] and

Whereas, the Conrad 30 Waiver program is an essential component for rural health care recruitment, yet the limit of 30 waivers per state has remained stagnant since Congress increased the cap to 30 per state per year in 2003; and

Whereas, there is substantial state-level variation in use of Conrad 30 waivers, with some states filling all 30 slots rapidly while other states do not use their full allotment; therefore be it

RESOLVED, that our American Medical Association update existing policy D 255.985 ”Conrad 30- J1 Visa Waivers” to address current challenges and modernize the program by addition as follows:

- advocate for the redistribution (or recapture) of unused waiver capacity to high-need states; and
- advocate for the streamlining of administrative requirements to shorten timelines for employers and physicians, such as establishing a medical national interest exception and implementing mandatory expedited processing for physician and medical trainee applicants.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

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3. Malayala S, Adhikari R, Vasireddy D, Atluri P, Bali A. Medically underserved areas and International Medical Graduates (IMGs) in the United States: challenges during the COVID-19 era. J Community Hosp Intern Med Perspect. 2021 Jun 21;11(4):457-463. doi: 10.1080/20009666.2021.1915548. PMID: 34211648; PMCID: PMC8221155. https://pmc.ncbi.nlm.nih.gov/articles/PMC8221155/
4. American Immigration Council. Foreign-Trained Doctors are Critical to Serving Many U.S. Communities. January 2018. https://www.americanimmigrationcouncil.org/wp-content/uploads/2025/01/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf
5. https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program

RELEVANT AMA POLICY

1. Conrad 30 J-1 Visa Waivers D 255.985 (2024.)

2. Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access H-420.946 (2024.)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-26)

Introduced by: Virginia

Subject: Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness

Referred to: Reference Committee B

Whereas, our American Medical Association encourages hospitals to incorporate disaster plans that address barriers to staff responses during disasters, as stated in H-225.941; and

Whereas, critical medical treatments such as dialysis, chronic oxygen therapy, chemotherapy, and radiation therapy are essential for patient survival and require coordinated planning during emergencies; and

Whereas, interdisciplinary models of cooperative planning involving city/regional authorities, hospitals, physicians, medical equipment providers, and transportation companies can enhance disaster preparedness and response; therefore be it

RESOLVED, that our American Medical Association develop model state legislation and guidelines for incorporating critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support interdisciplinary cooperative planning agreements to ensure continuity of critical medical treatments during emergencies. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

RELEVANT AMA POLICY

Hospital Disaster Plans and Medical Staffs H-225.941

1. Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-26)

Introduced by: Virginia

Subject: Protecting Mental Health Treatment Privacy in Legal Proceedings

Referred to: Reference Committee B

Whereas, the Medical Society of Virginia's SafeHaven program was established in 2020 and provides a confidential resource for healthcare professionals to seek mental health treatment without fear of professional repercussions; and

Whereas, the confidentiality of mental health treatment is essential to encourage healthcare professionals to seek necessary care; and

Whereas, the discoverability of mental health treatment records in civil and criminal trials may deter individuals from seeking treatment due to concerns about privacy and legal exposure; and

Whereas, the American Medical Association has previously adopted a multitude of policies supporting efforts to address issues related to career fatigue and wellness in healthcare professionals and students; therefore be it

RESOLVED, that our American Medical Association develop model state legislation ensuring that mental health treatment records are protected from discoverability in civil and criminal trials, thereby fostering a safe and supportive environment for healthcare professionals to seek necessary mental health care. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
    a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
    b. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
10. Our AMA supports physicians who are caregivers to alleviate physician burnout.

Factors Causing Burnout H-405.948

1. Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Physician Health Programs H-405.961

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state’s physician health program without fear of loss of license or employment.

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-26)

Introduced by: Mississippi

Subject: Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation

Referred to: Reference Committee B

Whereas, multiple studies show the tremendous financial and human resource burden imposed upon physician practices by health insurance companies; and

Whereas, while filling medications is foundational to PDA, it does not guarantee that a patient will take the medication; and

Whereas, PDA metrics cause physicians to assume more than a reasonable amount of responsibility for patient behavior; and

Whereas, patient behavior regarding adherence to treatment plans is poorly controlled by physicians; and

Whereas, it is unfair, burdensome, and unrealistic to continue associating PDA with physician rating and compensation; therefore be it

RESOLVED, that our American Medical Association advocate against the use of patient Prescription Drug Adherence (PDA) as a quality metric tied in any manner to physician ratings or compensation. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

RELEVANT AMA POLICY

D-450.958 Pain Medicine and Patient Adherence in Quality Care Assessment

1. Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys.
2. Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15 Modified: CMS Rep. 07, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-26)

Introduced by: Mississippi

Subject: Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians

Referred to: Reference Committee B

Whereas, patients can receive expensive medications much cheaper when those medications are prescribed by a provider employed by a covered entity under the 340B program; and

Whereas, independent physicians are not covered entities; and

Whereas, it is favorable for patients have access to expensive medications for lower costs but unfavorable that patients of independent physicians are excluded from the lower cost medications; and

Whereas, this practice unfairly punishes patients of independent physicians; and

Whereas, this practice incentivizes patients to seek care from physicians and non-physician prescribers employed by covered entities in lieu of independent physicians; and

Whereas, this practice unfairly places independent physicians at a disadvantage regarding building and maintaining a medical practice; therefore be it

Resolved, that our American Medical Association advocate for the patients of any physician practicing in the same county (or equivalent region) that contains a covered 340B entity to receive reduced cost medications under the 340b program through the covered entity's contracted pharmacy. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

RELEVANT AMA POLICY

H-110.985 340 B Drug Discount Program
Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices; and (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. [Res. 255, A-18 Appended: BOT Rep. 08, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding

Referred to: Reference Committee B

Whereas, The National Institutes of Health (NIH) supports medical investigations that translate into life-saving treatments, providing the foundation for 99.4% of new treatments approved by the Food and Drug Administration between 2010 and 2019, and directly impacting patient care, clinical practice, and public health nationwide;[1] and

Whereas, our American Medical Association (AMA) has continuously championed the necessity of robust NIH funding;[2] and

Whereas, the AMA has engaged in strong federal advocacy to protect this enterprise, including sending a July 2025 letter to Congressional leadership warning that proposed funding cuts and radical reorganizations of the NIH would have serious consequences for the health of the American people and local economies;[2] and

Whereas, a new administrative framework termed "Gold Standard Science" has been utilized to abruptly terminate hundreds of active grants deemed misaligned with newly defined agency priorities;[3] and

Whereas, between February 28 and April 8, 2025, the NIH terminated 694 active grants cumulatively valued at $1.81 billion, and the NIH Director has indicated that previously reinstated grants will face non-renewal during the 2026 cycle if they do not conform to these ideological priorities;[4] and

Whereas, these abrupt mid-project terminations disrupted approximately 1 in 30 active clinical trials nationwide, halting 383 clinical studies (3.5% of actively recruiting trials) and directly affecting more than 74,000 participants;[5] and

Whereas, canceling active clinical trials for political or ideological reasons leaves enrolled patients facing delayed treatments, lost access to experimental medications, or unmonitored medical device implants, thereby profoundly breaching bioethical obligations to human subjects and eroding public trust; and

Whereas, the federally-funded research ecosystem is facing severe liquidity constraints because the White House Office of Management and Budget (OMB) missed the deadline to authorize release of FY 2026 funds to the NIH, preventing spending on essential expenses (e.g., salaries) and preventing disbursement of newly appropriated research capital;[6] and

Whereas, in the 12-month period ending in June 2025, U.S. academic institutions were awarded nearly $5 billion less in NIH research grants compared to the prior year as a result of systemic disruptions and slowdowns in the federal grant awarding process;[7] and

Whereas, these disruptions have persisted into the current cycle, with the NIH awarding only 1,189 new and competitive renewal grants this fiscal year through early March 2026, a drastic reduction from the 2,322 grants awarded during the same period last year, and 74% fewer grants than in FY 2021-2024, despite Congress enacting increased funding for the NIH;[8,9] and

Whereas, administrative mandates forcing the "forward-funding" or "front-loading" of multi-year NIH grants, a practice requiring the agency to distribute the entire multi-year grant value upfront out of a single year's appropriation, mathematically starve the pipeline of new clinical trials, resulting in 5,564 fewer grants funded in FY 2025 and driving down overall grant success rate to a historic low of ~17%;[10] and

Whereas, the AMA joined over 40 physician organizations in an March 2025 letter sounding the alarm that the unilateral implementation of a strict 15% cap on indirect (Facilities and Administrative) costs will inflict "profound and generational" damage on scientific progress by severely underfunding the essential infrastructure, equipment, and compliance personnel necessary to responsibly conduct medical studies;[11] and

Whereas, this arbitrary cap, which replaces actual historical averages of 38% to 39%, is projected to reduce federal funding to academic institutions by $5.24 billion annually, causing an estimated $6.1 billion decrease in the United States Gross Domestic Product (GDP) and creating massive operational deficits that threaten active clinical trials;[1] therefore be it

RESOLVED, that our American Medical Association amend Policy D-460.960 by addition and deletion to read as follows:
2. Our AMA advocates against reorganization, consolidation or re-prioritization of the NIH when such action:

a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care; and
c. is driven by frameworks that bypass validated, merit-based scientific peer-review processes or violate ethical obligations to human subjects. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for the immediate approval of the NIH spend plan and the full apportionment of congressionally appropriated funds by the Office of Management and Budget (OMB), and advocate against any future use of administrative apportionment delays to artificially restrict or impound biomedical research funding (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate against the mandatory "forward-funding" or "front-loading" of multi-year NIH grants, which is the practice of distributing the entire multi-year total value of a grant upfront out of a single fiscal year's limited appropriation rather than the historical practice of disbursing annual grant allowances from the appropriations of those individual years, to prevent drastic reductions to the total number of potential new grants and clinical trials that can be awarded (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy D-460.961, which opposes arbitrary and unilateral caps on indirect costs in federal grants. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

REFERENCES

1. Kelkar, A.H. "U.S. Research Leadership at a Crossroads: The Impact of Reducing NIH Indirect-Cost Coverage," *N Engl J Med* 2025;392:2081-2084.
2. Mukkamala, B. "Slashing NIH funding imperils the foundation of medical research," AMA News Wire (August 1, 2025).
3. "Leading in Gold Standard Science: An NIH Implementation Plan," National Institutes of Health (August 22, 2025).
4. "NIH Terminates 694 Grants Worth $1.81 Billion," HealthDay (May 8, 2025).
5. "NIH Grant Terminations Disrupt 1 in 30 Clinical Trials," AJMC / *JAMA Internal Medicine* (November 17, 2025).
6. "NIH funding in limbo as OMB misses 30-day deadline and what it means for your grants," R&D World (March 5, 2026).
7. "Clinical trials and training stalled as billions in NIH funds sit idle," AAMC (August 15, 2025).
8. "Despite boosted funding, NIH still slow to award grants," Fierce Biotech (March 16, 2026).
9. "NIH grant awards are again lagging far behind historical averages, analysis shows," STAT (March 17, 2026).
10. Rock-Torcivia, J. "The end of the payline: What the NIH's new funding model means for your lab," R&D World (March 10, 2026).
11. Lubell, J. "Cap on NIH research grants would leave 'generational' damage," AMA News Wire (April 2, 2025).

RELEVANT AMA POLICY

H-460.930 Importance of Clinical Research
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports development of community and practice-based clinical research networks. [CSA Rep. 2, I-96 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CME Rep. 4, I-08 Modified: CSAPH Rep. 01, A-18]

D-460.960 Opposing Unwarranted National Institutes of Health Research Institute Restructuring
1. Our American Medical Association advocates for an independent NIH reorganization advisory commission composed of interested parties, including physicians, scientists, researchers, academics, and patient advocacy organizations, to ensure that any proposed restructuring of the NIH is guided by medical, scientific, and public health expertise and serves the best interests of patients and the scientific community
2. Our AMA advocates against reorganization or consolidation of the NIH when such action:
    a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
    b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care.
3. Our AMA supports study of the short- and long-term impacts of federal biomedical research funding reductions, including medical innovation, the healthcare workforce, medical education, public health and local economies and communities.
4. Our AMA publicly opposes the reduction of research funding and funding opportunities from the NIH. [Res. 219, A-25]

D-460.961 NIH Grant Funding for Medical Research

1. H-460.973 Protection of Scientific Freedom from Special Interest Groups Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to oppose arbitrary and unilateral caps on indirect costs, including facilities and administrative reimbursements, in federal grants (including NIH grants and other governmental funding agencies) or any funding policy that restricts critical early-stage and independent research as well as grant-funded training programs.
2. Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to protect the ability of research institutions to negotiate indirect cost rates to ensure the sustainability of federally funded biomedical research.
3. Our AMA will advocate for targeted reforms to streamline administrative and regulatory requirements in order to achieve sustainable cost reductions while preserving essential research infrastructure. [Res. 502, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Prohibiting Pharmacy Benefit Managers from Owning Pharmacies

Referred to: Reference Committee B

Whereas, pharmacy benefit manager (PBM) practices harm patients by raising patient costs, limiting access to necessary medications, and threatening the viability of independent pharmacies, increasing pharmacy deserts[1, 2]; and

Whereas, PBMs steer patients toward pricier drugs and charge steep markups on what would otherwise be inexpensive medicines. and extract billions of dollars in hidden fees from patients, pharmacists, and health systems[1]; and

Whereas, PBMs frequently push higher-priced medications even when an inexpensive generic of a drug is available. PBMs sometimes have a financial reason to push patients to take a more expensive brand-name product. The higher the original sticker price, the larger the discounts the PBMs can demand, even if the ultimate discounted price of the brand-name drug remains higher than the cost of the generic[3]; and

Whereas, mergers and buyouts have concentrated 80 percent of the industry into the hands of three major players: CVS Caremark, owned by CVS Health; Express Scripts, owned by Cigna; and Optum Rx of United Health Group, minimizing any competition[4]; and

Whereas, in 2025, Arkansas passed legislation placing limits on PBMs' ability to own, manage, or control pharmacies[5] and Louisiana passed legislation increasing regulations on how PBMs operate[6]; and currently, Arizona, Tennessee, and Oklahoma are considering legislation that would prohibit PBMs from owning or holding, directly or indirectly, pharmacy permits in the states[7]; therefore be it

RESOLVED, that our American Medical Association develop model state legislation empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies**.** (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

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1. FTC releases interim staff report on prescription drug middlemen. News Release. FTC. July 9, 2024. Accessed May 30, 2025. https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen
2. https://www.warren.senate.gov/newsroom/press-releases/warren-hawley-harshbarger-auchincloss-introduce-bipartisan-bill-to-cut-drug-costs-rein-in-pharmacy-benefit-managers-pbms
3. https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending
4. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2025.pdf
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6. https://www.legis.la.gov/legis/ViewDocument.aspx?d=1401324
7. https://www.quarles.com/newsroom/publications/state-legislative-trends-restricting-pbm-ownership-of-pharmacies

RELEVANT AMA POLICY

D-120.919 Pharmacy Benefit Manager (PBM) Divestiture and Transparency

1. Our American Medical Association will work with appropriate parties to support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership by insurance companies.

2. Our AMA will work with appropriate parties to support and lobby for divestment of PBMs from owning affiliate pharmacies and infusion centers. [Res. 210, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-26)

Introduced by: New York

Subject: Medical Student Loans Should Not Be Capped

Referred to: Reference Committee B

Whereas, the H. R. 1 - One Big Beautiful Bill Act restricts medical school debt starting July 1, 2026, capping unsubsidized loans at $50,000 annually with a cap of $200,000, ending the unlimited Grad PLUS program, and imposing a new lifetime cap of $257,500 across all higher education; and

Whereas, costs of attending medical school can exceed $300,000, and the lack of federal loans will force students to rely on private loans with higher interest rates and less flexible terms; and

Whereas, these changes will disproportionately affect minority and low-income students and worsen physician shortages; and

Whereas, these restrictions come in addition to new conditions on the Public Service Loan Forgiveness program, which enables healthcare workers to work in high-need areas to erase debt over a decade; and

Whereas, the default rate for physicians is very low, approximately 5%; therefore be it

RESOLVED, that our American Medical Association oppose the caps on medical student debt as a result of the H. R. 1 - One Big Beautiful Bill Act. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-26)

Introduced by: New York

Subject: Oppose Medicare Efficiency Adjustments

Referred to: Reference Committee B

Whereas, the Centers for Medicare & Medicaid Services (CMS) released its 2026 Medicare Physician Payment Schedule (PFS) and included a new number called an efficiency adjustment; and

Whereas, CMS applied this efficiency adjustment of a 2.5 percent decrease to work RVUs and physician intra-service time for most services on the assumption that physicians have gained efficiency in providing them, excluding time-based services such as E/M; and

Whereas, CMS claims to use the Medicare Economic Index (MEI) to determine this number, yet physicians do not receive MEI-based updates; and

Whereas, CMS ignores extensive data collection that could be used, instead relying on flawed physician surveys to estimate physician time; therefore be it

RESOLVED, that the American Medical Association support all efforts, whether by legislation or regulation, to restrict the use of arbitrary new factors such as the efficiency adjustment used in the 2026 Medicare Physician Payment Schedule. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-26)

Introduced by: New York

Subject: Protecting Healthcare as a Sensitive Location

Referred to: Reference Committee B

Whereas, the Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA) have aligned policy on healthcare as sensitive locations and protected areas for everyone, including immigrants (MSSNY policy207.299; AMA policyD-160.921); and

Whereas, AMA policy opposes criminalization of medical care provided to undocumented immigrant patients, including collection and reporting of immigration status or withholding of federal funds (H-440.876); opposes use of medical information by immigration authorities (H-7315.966); and opposes mass deportation and targeting of health care workers and medically vulnerable patients based on immigration status (H-440.793); and

Whereas, there exists limited New York State guidance and limited national accreditation standards for health care facilities on immigration enforcement; and

Whereas, federal immigration enforcement is increasingly undermining patient care by entering health care facilities and accessing health information, and patients fearing immigration enforcement's presence in healthcare facilities are less likely to go there for routine healthcare, preventive care, or emergencies which leads to them presenting later and sicker and having worse health outcomes; therefore be it

RESOLVED, that our American Medical Association reaffirm its policies Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare (D-160.921), Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients (H-440.876), Mass Deportation as a Public Health Issue (H-440.793), and Patient and Physician Rights Regarding Immigration Status (H-315.966) (Reaffirm HOD Policy); and be it further

RESOLVED that our AMA collaborate with state societies where immigration enforcement in health care facility guidance has been developed, and with the AMA Advocacy Resource Center, to develop model legislation and regulation for states to adopt to better protect patients and health care workers from inappropriate intrusion of federal immigration agents in health care facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, to develop health care facility standards related to immigration enforcement. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-26)

Introduced by: Michigan

Subject: Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs

Referred to: Reference Committee B

Whereas, in traditional Medicare fee-for-service, hospital care accounts for approximately 41–43 percent of total Medicare spending, while physician and clinical services account for approximately 22–24 percent; and

Whereas, inpatient and outpatient hospital facility expenditures represent the largest single driver of total cost performance within the Medicare Shared Savings Program (MSSP) and materially affect shared savings and downside risk reconciliation; and

Whereas, hospital outpatient services have been among the fastest-growing components of Medicare spending over the past decade, in part due to site-of-service payment differentials that allow hospital outpatient departments to bill higher rates than independent physician offices for comparable services; and

Whereas, under the Medicare Shard Savings Program (MSSP), total cost of care calculations for an Accountable Care Organization (ACO) include all Medicare expenditures incurred by ACO-assigned beneficiaries, including hospital inpatient and outpatient facility spending, regardless of whether the hospital maintains a participation or financial accountability agreement with the ACO contracting entity; and

Whereas, physicians participating in ACO contracting entities may be exposed to shared savings reductions or downside financial risk based on hospital expenditures over which they do not have direct operational or financial control; and

Whereas, hospitals that receive substantial volumes of ACO-attributed Medicare beneficiaries benefit from patient flow generated through ACO care coordination efforts yet, are not uniformly required to assume proportionate financial accountability for total cost performance; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services establish policies requiring hospitals that receive substantial expenditures attributable to ACO-assigned beneficiaries to enter defined participation and financial accountability agreements with the relevant ACO contracting entity (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that, absent such defined participation and accountability agreements, hospital expenditures for ACO-assigned beneficiaries not be included in total cost of care reconciliation calculations under the Medicare Shared Savings Program or other advanced alternative payment models (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced transparency of hospital facility spending attributable to ACO-assigned beneficiaries within benchmarking and reconciliation methodologies (Directive to Take Action); and be it further

RESOLVED, that our AMA to study and report on policy mechanisms to ensure equitable financial accountability for hospital expenditures attributed to Medicare ACOs, including mechanisms addressing site-of-service payment differentials and facility fee impacts. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

REFERENCES

1. Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy. March 13, 2025.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Shared Savings Program Fast Facts and Performance Year Financial Results. 2024.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-26)

Introduced by: Kansas

Subject: Opposing the Practice of Jury Anchoring in Medical Liability Cases

Referred to: Reference Committee B

Whereas, medical professional liability costs are increasing for physicians across the country; and

Whereas, from 2013 to 2023, there was approximately a 67 percent increase in the number of medical liability awards of $10 million or more; and in 2023, 57 verdicts of $10 million or more were awarded, with more than half of these verdicts exceeding $25 million[1]; and

Whereas, these increased liability claim costs and resulting premium increases stem in part from new trial tactics such as jury anchoring, in which plaintiffs' attorneys take advantage of a phenomenon known as "anchor bias," whereby individuals give disproportionate weight to the initial information they receive when making decisions; and

Whereas, plaintiffs' attorneys in medical liability litigation employ anchoring bias to obtain outsized non-economic damage awards by requesting amounts that are not based on objective evidence; and

Whereas, outsized damage awards are a major driver of medical professional liability insurance claims, which in turn drive premium increases, contribute to physician shortages, and threaten patient access to care; therefore be it

RESOLVED, that our American Medical Association opposes the practice of jury anchoring in medical liability litigation, specifically as it related to non-economic damages. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

REFERENCES

1. Nuclear Verdicts: How Social Inflation Impacts Physicians and Patients, Robert E. White Jr., President, The Doctors Company and TDC Group (2024). Accessible at https://www.thedoctors.com/articles/nuclear-verdicts-social-inflation-healthcare-impact-physicians-patients
2. Policy Research Perspectives Upward Trajectory of Medical Liability Premiums Persists for Sixth Year in a Row by Allen Hardiman, PhD (2024). Accessible at https://www.ama-assn.org/system/files/prp-mlm-premiums-2025.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-26)

Introduced by: American College of Lifestyle Medicine

Subject: Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs

Referred to: Reference Committee B

Whereas, rural health in the United States is in crisis per decades of hospital closures, clinician shortages and losses of essential services that have left millions of people without reliable access to care and worsened health outcomes; and

Whereas, chronic challenges to providing adequate rural health were compounded by the newly $1 trillion cuts to Federal health care funding; and

Whereas, the Congress established the Rural Health Transformation Program (RHTP) as a partial remedy for those cuts by providing $50 billion in awards to rebuild and reshape states' health care systems, not backfill…operating budgets; and

Whereas, the RHTP's primary objective is to "Make Rural America Healthy Again" by strategies that will support rural health innovations and new access points to promote preventative health and address root causes of diseases via Projects that will use evidence-based, outcomes driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care; and

Whereas, fifty percent of the $50 billion must be divided equally among states with approved applications ($100 million per state per year; and the remaining 50% will be distributed by CMS ($5 billion per year) based on factors identified in the Notice of Funding Opportunity (NOFO); and

Whereas, this funding structure ensures a minimum level of support for every participating state along with a substantial discretion for the CMS to further support states whose project priorities align with Federal interests; and

Whereas, within the NOFO, states are required to implement at least three of the ten activity categories described in Section 71401. Three of these categories closely align with the principles and practice of Lifestyle Medicine: (a) promoting evidence-based, measurable interventions to enhance prevention and chronic disease management; (b) advancing consumer-facing, technology-driven solutions for chronic disease prevention and management; and (c) providing payments to health care providers for covered health care items and services; and

Whereas, additional delineation of these categories highlights collaborative strategies for rural health facilities, including: (a) advancing sustainable access through initiatives that enhance practitioner efficiency, operational sustainability, and shared coordination of technology and clinical services across primary, specialty, and emergency care; and (b) promoting innovative care models that aim to improve health outcomes, optimize care coordination, and enable

flexible delivery structures, supported by payment mechanisms that align provider and Accountable Care Organizations' incentives with cost reduction, quality improvement, and care delivery in lower-cost settings; and

Whereas, some aspects of the current Administration's preferred policies may be acceptable to healthcare systems, such as including nutrition training in continuing medical education; and

Whereas, the principles and practice of Lifestyle Medicine are grounded in evidence-based, reproducible, and measurable health care, emphasizing the identification and treatment of underlying drivers of chronic disease through a collaborative physician–patient partnership; and

Whereas, the principles and practices of Lifestyle Medicine seek to reduce the long-term costs of care for chronic diseases through reduction of the need for medications and repetitive therapies; therefore be it

RESOLVED, that our American Medical Association encourage State Constituent Medical Associations to work collaboratively with their respective State Departments of Health to incorporate implementation of the principles and practices of lifestyle medicine within the design of their respective State's Rural Health Transformation Program, thereby satisfying some of the scored requirements/categories of the Rural Health Transformation Program application (New HOD Policy); and be it further

RESOLVED, that our AMA encourage State Constituent Medical Associations to work collaboratively with their respective State Departments of Health to include nutrition continuing medical education as an effective strategy to satisfy one of the scored requirements/categories of the Rural Health Transformation Program application. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

REFERENCES

1. Moy E, McClellan M. The Rural Health Transformation Program—an avenue for promoting administrative policies. N Engl J Med. Published online 2026. Accessed April 14, 2026.
https://www.nejm.org/doi/full/10.1056/NEJMp2515454
2. American Medical Association. What to know about a chance at $50 billion in rural health funding. Accessed April 14, 2026.
https://www.ama-assn.org/public-health/population-health/what-know-about-chance-50-billion-rural-health-funding
3. American College of Lifestyle Medicine. A family physician's introduction to lifestyle medicine. Supplement to The Journal of Family Practice. 2022. Accessed April 14, 2026.
https://cdn.mdedge.com/files/s3fs-public/aclm_2022_final_set_0.pdf
4. American College of Lifestyle Medicine. Transforming rural health through lifestyle medicine. Accessed April 14, 2026.
https://lifestylemedicine.org/transforming-rural-health-through-lifestyle-medicine/

RELEVANT AMA POLICY

H-465.994 Improving Rural Health

1. Our American Medical Association:
- supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
- urges physicians practicing in rural areas to be actively involved in these efforts, and
- 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:
- Encourage more research to identify the unique needs and models for delivering public health

and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- 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.
- 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 Reaffirmed: Res. 237, I-25 Reaffirmed: CMS Rep. 03, I-25]

H-465.997 Access to and Quality of Rural Health Care
1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.
2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.[CMS Rep. G, A-87 Modified: Sunset Report, I-97 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed: CMS Rep. 1, A-21 Reaffirmed: BOT Rep. 07, I-24 Reaffirmed: CMS Rep. 03, I-25]

H-465.972 Payment Models to Sustain Rural Hospitals
1. Our American Medical Association believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to:
- support and monitor novel payment models for rural hospitals and encourage uniform reporting; and
- support educating patients, physicians, and non-physician practitioners on alternative payment models for rural hospitals.

2. Our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care.
3. Our AMA will work to vigorously oppose Medicaid cuts as they significantly impact at-risk rural hospitals. [CMS Rep. 03, I-25]

H-170.995 Healthful Lifestyles
The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health

lifestyles.[BOT Rep. A, NCCMC Rec. 48, A-78 Reaffirmed: CLRPD Rep. C, A-89 Res. 402, I-94 Reaffirmed: CSA Rep. 6, A-04 Reaffirmed: BOT Rep. 8, I-06 Reaffirmed: CSAPH Rep. 01, A-16]

H-425.972 Healthy Lifestyles

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.[Res. 423, A-12 Appended: Res. 959, I-17 Reaffirmed: Res. 302, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-26)

Introduced by: Ohio

Subject: Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians

Referred to: Reference Committee B

Whereas, effective 01/01/2026, The CY 2026 Physician Fee Schedule final rule (CMS-1832-F) significantly reduced the practice expense portion of physician payments for services provided in the facility setting; and

Whereas, cuts to practice expense will be destabilizing to the healthcare system, causing significant disruption in access to healthcare services, particularly for those in rural and underserved areas, by removing urgently needed resources from physicians; and

Whereas, many specialists are classified as “facility-based” but work as independent practices or professional corporations and are not directly salaried by a hospital, as the rule suggests. As a result, they incur rent for their own office space and utility expenses, employ and train administrative and clinical support staff, and shoulder ongoing costs for equipment, information technology, quality improvement programs, biosafety and compliance infrastructure, which should be adequately compensated by CMS; and

Whereas, independent physician groups operate around the country, tending to be smaller local, rural or regional groups. Groups like these are reliant on their expected venue for services provided, and certainly expend significant practice expense. These physician groups do not have the ability to absorb significant cuts to payments the way a large health system may be able. These cuts will force many independent physician groups to sell their practices to hospitals, health systems, or larger entities – in direct contradiction to CMS’ states goals[1]; and

Whereas, these practice expense cuts will negatively impact all medical specialties that perform services in the hospital-based setting, causing across-the-board harm to our patients and our communities; therefore be it

RESOLVED, that our American Medical Association write and promote federal legislation to reverse CY 2026 Physician Fee Schedule (CME-1832-F) reductions to facility-based practice expenses payments for physicians – retroactive to 01/01/2026 – and codify future payment updates by linking these payments to the Medicare Economic Index (MEI). (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

REFERENCES

1. https://www.hospitalmedicine.org/letters/shm-leads-multispecialty-effort-to-stop-facility-based-practice-expense-cuts/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-26)

Introduced by: American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Pediatrics, Minnesota Medical Association

Subject: Universal Newborn Congenital Cytomegalovirus Screening

Referred to: Reference Committee B

Whereas, congenital Cytomegalovirus (cCMV) is the leading cause of non-genetic birth defects in the United States, and can cause sensorineural hearing loss, lasting seizure disorders, and other developmental disorders; and

Whereas, roughly one in every 200 United States newborns have cCMV, most are asymptomatic at birth, and 2,230 infants develop sensorineural hearing loss annually; and

Whereas, cCMV must be diagnosed within the first 21 days of life to distinguish it from postnatal CMV infection, which is not associated with hearing loss or other developmental disorders; and

Whereas, the American Academy of Otolaryngology – Head and Neck Surgery supports universal newborn cCMV screening;[1] and

Whereas, Minnesota and Connecticut have adopted universal newborn cCMV screening; and

Whereas, many cCMV positive newborns who are asymptomatic at birth develop late-onset hearing loss;[2 3] and

Whereas, children with late-onset hearing loss have a mean age of detection of 27 months; and

Whereas, the critical age for intervention in childhood hearing loss, including speech and language services and amplification, is prior to age 18-20 months; and

Whereas, after Minnesota implemented universal cCMV screening, the time of first audiology visit dropped from 8.5 months of age to roughly 25 days of age on average, and the number of diagnoses jumped from about 3 per year to 61 per year;[4] and

Whereas, early detection of cCMV offers the option of antiviral therapy, which has been associated with a decrease in severity and a delay in the progression of hearing loss; therefore be it

RESOLVED, that our American Medical Association support state legislation and policies requiring universal newborn screening for congenital cytomegalovirus (cCMV) (New HOD Policy); and be it further

RESOLVED, that our AMA support federal legislation and policies that expand newborn screening for congenital cytomegalovirus (cCMV) and increase funding for public awareness, prevention, and research related to congenital cytomegalovirus infection. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

REFERENCES

1. American Academy of Otolaryngology – Head and Neck Surgery position statement: Universal newborn congenital cytomegalovirus screening. https://www.entnet.org/resource/universal-newborn-congenital-cytomegalovirus-ccmv-screening/
2. Rohren L, Shanley R, Smith M, Yue M, Huang TC, Nelson P, Hernandez-Alvarado N, Schleiss MR, Gravel KE. Congenital Cytomegalovirus-Associated Sensorineural Hearing Loss in Children: Identification Following Universal Newborn Hearing Screening, Effect of Antiviral Treatment, and Long-Term Hearing Outcomes. Ear Hear. 2024 Jan-Feb 01;45(1):198-206. doi: 10.1097/AUD.0000000000001411. Epub 2023 Aug 11. PMID: 37563758; PMCID: PMC10718220.
3. Richard, C., Shakhtour, L., Gallo, N., Smith, R., MacDonald, C.B., Gentry, R., Scheerer, H., Arnold, S.R. and Carrillo-Marquez, M.A. (2025), Audiological Outcomes of Cytomegalovirus Saliva PCR-Positive Newborns in Support of Universal Screening. Otolaryngol Head Neck Surg, 173: 1245-1253. https://doi.org/10.1002/ohn.1332
4. Holden, L., Carlson, A.M., Jayawardena, A., Meyer, A., Roby, B., Lunos, S., Novak, J., Rabusch, S. and Redmann, A.J. (2026), The Impact of Mandated Universal Screening for Congenital Cytomegalovirus: The Minnesota Experience. Otolaryngol Head Neck Surg. https://doi.org/10.1002/ohn.70158

RELEVANT AMA POLICY

H-245.970 Early Hearing Detection and Intervention

1. Our AMA supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner.

2. Our AMA supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-26)

Introduced by: Georgia

Subject: Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage

Referred to: Reference Committee B

Whereas, Medicare is a critical federal program that provides health insurance coverage to over 60 million Americans, including seniors and individuals with disabilities; and

Whereas, beneficiaries currently have the option to enroll in either Traditional Medicare (Parts A and B) or a Medicare (Dis)Advantage (Part C) plan offered by private insurers, allowing them to choose the coverage that best meets their individual health and financial needs; and

Whereas, the right of beneficiaries to choose between Traditional Medicare and Medicare Advantage should be preserved; and

Whereas, the right of beneficiaries to change their coverage from time to time should be more seamless, readily identifiable, and flexible; and

Whereas, any efforts to limit or restrict access to either form of coverage—Traditional Medicare or Medicare Advantage—may undermine the principles of patient autonomy, equity, and access to care; and

Whereas, both Traditional Medicare and Medicare Advantage have unique benefits and limitations, and no single option is perfect for each patient; and

Whereas, AMA Policy H-330.878 supports Medicare plans that provide at a minimum all part A and B original services and advocates for better regulation and transparency on websites as well as maintaining publicly valuable databases of doctors in network; and

Whereas, AMA Policy H-285.902 urges CMS to ensure directory accuracy yearly and any significant changes as well as conduct reviews and reports to Medicare plan finder with penalty for failure to do so as well as adequacy of network both in ration of members to specialty and subspecialty as well as distances to specialty as CMS currently uses; and

Whereas, AMA Policy H-330.913 opposes bait and switch tactics of Medicare advantage plans whereby patients' and physicians' participation is based on a payment schedule (that often changes) which may result in physicians leaving the network while continuing to capture covered patients, thereby necessitating their identification of new in-network physicians; and

Whereas, AMA Policy D-330.930 acknowledges that Medicare Advantage plans may be misleading in their marketing and advertising concerning the lack of secondary coverages (Medigap policy) with Medicare Advantage plans and supports ongoing outreach and education efforts to raise public awareness and ensure equitable access; and

Whereas, the current Medicare enrollment process is fragmented across multiple platforms, private brokers, and marketing channels, creating confusion for beneficiaries attempting to compare coverage options; and

Whereas, unlike the Affordable Care Act marketplace administered through HealthCare.gov, Medicare lacks a single, unified, official online platform that presents standardized, neutral, and easily understandable plan comparisons[1]; and

Whereas, Medicare beneficiaries—particularly seniors and individuals with disabilities—are frequently targeted by aggressive telemarketing and third-party marketing organizations that may present biased or incomplete information[2]; and

Whereas, Medicare.gov currently operates the "Medicare Plan Finder" which allows beneficiaries to compare and shop for private Medicare Advantage plans and stand-alone Part D plans, however the most recent update in 2025 frequently produced erroneous and conflicting information about which providers were in network[3]; and

Whereas, the collection and dissemination of beneficiary data by third-party marketing entities raises significant concerns regarding privacy, security, and unauthorized solicitation, and equitable access to Medicare information requires robust outreach and education for rural, underserved, elderly, disabled, and technologically disadvantaged populations; therefore be it

RESOLVED, that our American Medical Association advocate for the development and maintenance overseen by the Centers for Medicare & Medicaid Services of a centralized, official Medicare enrollment platform that provides clear, neutral, accurate, and easily understandable comparisons of coverage options under Traditional Medicare, Medicare Advantage, and supplemental coverage, including information on provider networks, prior authorization requirements, benefits, and out-of-pocket costs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for ongoing oversight and evaluation of such platform to ensure the accuracy of plan and directory information, neutrality, usability, accessibility, and protection of beneficiaries from deceptive or coercive practices (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal policies that prohibit telemarketing firms and third-party marketing organizations from directly enrolling Medicare beneficiaries, and instead require that beneficiaries be directed to the official Medicare enrollment platform for plan enrollment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for robust privacy and data security safeguards, including disclosure of data breaches, within any official Medicare enrollment platform, including protections against unauthorized access, misuse, or commercial exploitation of beneficiary information and prohibitions on the sale, transfer, or sharing of beneficiary enrollment data with third parties for commercial purposes (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for comprehensive outreach, education, and accessibility initiatives to ensure that beneficiaries and physicians, including those in rural, elderly, disabled, underserved, and technologically disadvantaged populations, can effectively use the official Medicare enrollment platform (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose legislative, regulatory, or administrative actions that would reduce access to, limit funding for, or otherwise disadvantage either Traditional Medicare or Medicare Advantage. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

REFERENCES

1. https://www.healthcare.gov
2. (2022). Deceptive Marketing Practices Flourish in Medicare Advantage [Review of Deceptive Marketing Practices Flourish in Medicare Advantage]. United States Senate Committee on Finance. https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Adv a ntage.pdf
3. Pugh, T. (2025, October 17). Medicare will improve plan finder amid glitches for open enrollment. AARP. https://www.aarp.org/medicare/medicare-plan-finder-glitches/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-26)

Introduced by: Georgia

Subject: Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations

Referred to: Reference Committee B

Whereas, the use of artificial intelligence (AI), algorithms, and predictive analytics by health insurers and utilization review entities is rapidly expanding in both coverage determinations (including prior authorization and claims adjudication) and health insurance eligibility and underwriting decisions affecting applicants; and

Whereas, emerging state frameworks, including Georgia Senate Bill 444 (2026) recently passed by the Georgia Legislature, recognize that AI may serve as a clinical decision-support tool but must not replace independent human clinical judgment; and

Whereas, reliance on AI as the sole basis for adverse determinations—including denial of coverage, limitation of benefits, or denial or restriction of health insurance eligibility for applicants—risks inappropriate, non-individualized decision-making and may exacerbate inequities; and

Whereas, health insurance applicants and insured patients are frequently unaware when AI tools are used in eligibility, underwriting, or coverage determinations and are not provided meaningful explanations of how such tools influence decisions; and

Whereas, current processes often lack timely access to qualified human review, including physician review when clinical issues are implicated, particularly by professionals in the same specialty; and

Whereas, AI systems used in insurance eligibility, underwriting, and coverage determinations may introduce or perpetuate bias, opacity (“black box” decision-making), and variability in performance, without standardized requirements for auditability, validation, or regulatory oversight; and

Whereas, the absence of clear national standards for AI-assisted eligibility and coverage determinations creates inconsistent protections across states, markets, and payer types, including individual market applicants, employer-sponsored plans, and Medicare Advantage; and

Whereas, while AMA Policy H-480.940 establishes broad principles for augmented intelligence in health care, it does not specifically address payer use of artificial intelligence in insurance underwriting, eligibility determinations, applicant denial processes, required human review, applicant appeal rights, or regulatory safeguards governing adverse insurance decisions generated by AI systems; and

Whereas, physicians are ethically obligated to advocate for patients' access to medically necessary care and to oppose barriers created by non-transparent utilization management or underwriting practices; and

Whereas, due process protections—including transparency, explanation of decisions, and meaningful opportunities for appeal or reconsideration—are essential to safeguard both patients' access to medically necessary care and applicants' fair access to health insurance coverage; therefore be it

RESOLVED, that our American Medical Association oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or limitations of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance determination, including an explanation of the role of the system in the decision, in both coverage determinations and eligibility, underwriting, or enrollment decisions (Directive to Take Action); and be it further

RESOLVED, that our AMA support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular attention to applicant-facing eligibility, underwriting, and enrollment decisions. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-26)

Introduced by: Indiana

Subject: Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms

Referred to: Reference Committee B

Whereas, Indiana law defines an "urgent care facility"[1] as a freestanding facility that provides walk-in, episodic care for acute but non-life-threatening conditions, and specifically excludes hospital emergency departments from being classified as urgent care facilities under Indiana Code § 16-24.5-1-1; and

Whereas, there is currently no Indiana statute or Indiana Department of Health regulation requiring urgent care centers to post signage stating that they are not emergency rooms, which may contribute to patient confusion, particularly during urgent medical situations[1]; and

Whereas, the absence of clear signage distinguishing urgent care clinics from emergency departments may lead patients experiencing medical emergencies to mistakenly seek care at an urgent care center, potentially delaying necessary emergency treatment[3]; and

Whereas, several other states, including Texas and Colorado[2, 3, 4, 5, 6, 7], have adopted laws requiring freestanding emergency departments to post explicit signage identifying their emergency status and prohibiting the misuse of the term "emergency" by non-emergency providers; and

Whereas, Indiana's current transparency law for urgent care centers, enacted in 2020, requires disclosure of service prices on websites but does not address physical signage or language use that distinguishes urgent care centers from emergency departments; and

Whereas, greater signage transparency would empower patients to make informed decisions about where to seek care and reduce the risk of inappropriate facility use during a medical emergency; therefore be it

RESOLVED, that our American Medical Association advocate for federal regulatory or legislative action that would require clear and standardized signage for urgent care centers to distinguish them from hospital emergency departments. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-26)

Introduced by: Indiana

Subject: Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients

Referred to: Reference Committee B

Whereas, patients residing in nursing homes often present with complex, chronic medical conditions requiring specialized care beyond primary services; and

Whereas, nonphysician practitioners (NPPs), such as nurse practitioners and physician assistants, play a critical role in extending access to care in long-term care settings; and

Whereas, the delegation of care to NPPs without appropriate physician oversight may result in variability in the quality, accuracy, and complexity of care provided to medically fragile patients; and

Whereas, the involvement of a board-certified medical specialist in a patient's ongoing care plan ensures alignment with evidence-based practices, appropriate diagnostic assessments, and continuity of specialty care; and

Whereas, current CMS guidelines require primary care physicians to alternate face-to-face visits with non-physician practitioners for nursing home patients, yet no such requirement exists for medical specialists overseeing similar care; therefore be it

RESOLVED, that our American Medical Association support federal legislation or regulation to require a minimal standard for specialist care for patients in nursing homes, such that, when a board-certified medical specialist delegates visits to nonphysician practitioners in a nursing home setting, the physician specialist must personally conduct a face-to-face evaluation of the patient either in person or via telehealth no less than every third visit. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-26)

Introduced by: Academic Physicians Section

Subject: Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System

Referred to: Reference Committee B

Whereas, International Medical Graduates (IMGs) constitute twenty-five percent of the United State's physician workforce[1], representing a significant and essential component, particularly in specialties with critical shortages (e.g., Internal Medicine, Family Medicine, Psychiatry, Pathology, and Neurology) [6,7,] and other shortage specialties; and

Whereas, federally designated undeserved areas and rural areas are more likely to be served by IMGs, catering to 46 to 66 million Americans [2,3,] and

Whereas, IMGs serve vital roles in medical education and research [4], developing our nation's future physicians and health professionals as faculty members, researchers and preceptors in medical schools and training programs across the country; and

Whereas, many non-U.S. physicians who graduated from international and U.S. medical schools rely on non-immigrant employment-based visa programs in order to participate in graduate medical education [5,] and subsequently practice medicine in the undeserved areas; and

Whereas, proposals to substantially increase employment-based visa fees, as high as $100,000, has posed an unprecedented financial barrier for institutions;[1,2] sponsoring visa for these individuals; and

Whereas, employment-based visa fees could disproportionately limit access to residency training opportunities for qualified applicants; and

Whereas, employment-based visa fees could sharply increase the vacancy rate within residency programs and undermine teaching hospitals' capacity [7,] for providing clinical training and safety-net care to underserved populations**;** and

Whereas, the 2026 National Resident Matching Program (NRMP) Match cycle and the following waiver employment cycle would be the first major residency recruitment cycle, and the underserved area physician employment cycles potentially affected by implementation of such a visa fee; and

Whereas, no formal national analysis has been conducted to evaluate the potential impact of such a fee on IMGs participation in the Match, residency program recruitment, or physician workforce supply in underserved areas [11,12]; therefore be it

RESOLVED, that our American Medical Association, in conjunction with other key organizations, study the potential impact of a proposed $100,000 employment-based visa fee on:

- International Medical Graduates participation in the National Resident Matching Program (NRMP) Match; and
- Graduate medical education programs; and
- Critical access hospitals; and
- Waiver and non-waiver recruitment into all specialties; and
- Physician workforce development and access to care in communities across all 50 states and U.S. territories.

(Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

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RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the

quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training. [BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23; Reaffirmed: Res. 312, A-25; Reaffirmed in lieu of the first resolve: Res. 234, A-25]

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23

Protection for International Medical Graduates H-255.960
Our American Medical Association supports relevant interested parties in developing a confidential mechanism through which physicians can report workplace immigration related interviews, in order to identify and address potential instances of unfair treatment or targeting of international medical graduate physicians. [Res. 234, A-25]

Physician Visa Protection and Pathway to U.S. Permanent Residency D-255.967
1. Our American Medical Association advocates for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.
2. Our AMA advocates for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.
3. Our AMA advocates for the creation of a dedicated visa pathway specifically for physicians. [Res. 213, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-26)

Introduced by: California, Hawaii, Idaho, Oregon, Washington, Wyoming

Subject: Standby Capacity Payments and Health IT for Hospitals in Rural Areas

Referred to: Reference Committee B

Whereas, rural communities already suffering from physician shortages, hospitals closures, less health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality are at even greater risk with the significant $1 trillion in Medicaid and Affordable Care Act (ACA) funding cuts (CBO) recently imposed by Congress through the passage of H.R. 1; and

Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation Program that provides $50 billion to states to address rural health care challenges; and

Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA 10 or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural physicians and communities is even greater; and

Whereas, while the AMA has extensive policy on improving rural health provider shortages infrastructure, health care disparities, and access to care, this resolution includes additional specific policies that are warranted to augment AMA's rural health advocacy; and

Whereas, 54% of rural residents report that access to medical specialists is a problem in their 19 community and telehealth has helped to address some physician shortages, provide access to specialty care, and reduce patient burden of traveling long distances to receive care; and

Whereas, rural hospitals that have difficulty retaining subspecialists have developed telehealth programs in coordination with larger urban hospitals that allow them to consult on patient care as needed and treat complex patients at local facilities - helping patients avoid the cost and time associated with traveling long distances to larger medical centers; and

Whereas, a GAO analysis found that the availability of health care providers in counties with rural hospital closures was lower and declined more over time when compared to counties without rural hospital closures and a Health Affairs study found that the availability of physicians and the viability of hospitals are related which makes the argument that more should be done to sustain rural physician practices to protect the entire health care system in rural areas; and

Whereas, there is evidence that administrative requirements, which are a challenge for physicians regardless of setting, can impose additional challenges for physicians in rural areas such as a 2018 GAO study of Medicare quality improvement programs that found small and rural practices were more likely to receive a negative payment adjustment citing lack of technology, financial resources to hire staff to manage the programs, and limited capacity to monitor program requirements which ultimately led to 18% of rural physician practices being penalized in the Medicare quality payment program in 2022; and

for example, a California Department of Health Services study found that providers in rural areas don't have access to basic health information technology or networks to engage in data exchange and while there is wide adoption of EHRs among physicians, physicians who had not adopted EHRs were more likely to be in rural or solo practice; and

Whereas, more than half of current rural hospitals in the United States lack a maternity ward and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 700 rural hospitals in 2025 were at risk of closure due to financial problems; and

Whereas, hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, low public and private reimbursement, and declining birth rates. Labor and delivery units are one of the most expensive departments for hospitals to maintain, second only to emergency departments; and

Whereas, a study by the American Journal of Public Health that looked at adverse maternal outcomes in rural and urban areas across the country found that pregnant individuals residing in rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal mortality rates almost twice the rate of individuals in urban areas; and

Whereas, a CHQPR study shows that half of the patients in rural hospitals have private insurance and in most cases it is the amount that private insurance pays, not Medicaid that determines whether a rural hospital loses money. To preserve and enhance essential hospital services in rural areas, CHQPR recommends that small rural hospitals receive Standby Capacity Payments from both public and private payers to cover the hospital's fixed costs for maintaining essential services and access to necessary care; therefore be it

RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of H.R. 1, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and be it further

RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

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RELEVANT AMA POLICY

D-190-969 Rural Hospital Payment Models

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).

D-465.994 New Reimbursement System Needed for Rural Hospital Survival

Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

H-200.972 Primary Care Providers in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care,and prenatal care;

b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;

c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;

d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;

e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access
8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

H-465.997 Access to Quality Rural Health Care
1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.
2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

H-465.998 Addressing Payment & Delivery in Rural Hospitals
1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-26)

Introduced by: California, Hawaii, Oregon, Washington, Wyoming

Subject: Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas

Referred to: Reference Committee B

Whereas, according to a 2024 National Public Radio (NPR) investigation, half of the active duty U.S. military installations are located in federally designated health professional shortage areas (HPSAs), including maternal care deserts and as the military has downsized and outsourced health care over the last decade to private physicians and hospitals, military personnel and their families cannot find physicians accepting new patients, exacerbating the health care demands and access to care problems in rural areas; and

Whereas, the military is also contracting with more people to provide services on military bases, such as janitorial cleaning staff, rather than hiring them as employees and many of these people are low-income, uninsured women who need maternal health care but can't obtain it on or near the base; and

Whereas, many states have examples of successful maternal care models, such as the California Maternal Quality Care Collaborative (CMQCC) created by Stanford University School of Medicine in partnership with the State of California and multiple stakeholder organizations that used research, data, toolkits and outreach to reduce maternal mortality by 65% from 2006-2016; and

Whereas, there is a need to creatively engage in efforts to ensure that women have access to comprehensive reproductive health care and pregnant patients in rural regions have access to the care necessary to ensure healthy outcomes for both baby and mother; therefore be it

RESOLVED, that our American Medical Association urge the Department of Defense to provide comprehensive reproductive health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to comprehensive reproductive care and maternal care in rural areas and reduced maternal mortality rates. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

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12. Toolkits. California Maternal Quality Care Collaborative. https://www.cmqcc.org/resources-tool-kits/toolkits.

RELEVANT AMA POLICY

D-190-969 Rural Hospital Payment Models

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).

D-465.994 New Reimbursement System Needed for Rural Hospital Survival

Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

H-130-954 Non-Emergent Patient Transportation Systems

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

H-200.972 Primary Care Providers in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care,and prenatal care;
b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and

g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H-215.960 Hospital Consolidation
1. Our American Medical Association affirms that:
a. Health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs.
b. The AMA strongly supports and encourages competition in all health care markets.
c. The AMA supports rigorous review and scrutiny of proposed mergers to determine their
d. Antitrust relief for physicians remains a top AMA priority.
2. Our AMA will continue to support actions that promote competition and choice, including:
a. Eliminating state certificate of need laws.
b. Repealing the ban on physician-owned hospitals.
c. Reducing administrative burdens that make it difficult for physician practices to compete.
d. Achieving meaningful price transparency.
3. Our AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

H-465-981 Enhancing Rural Physician Practices
1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

H-465.998 Addressing Payment & Delivery in Rural Hospitals
1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.

3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-26)

Introduced by: Colorado, Arizona, Idaho, Utah, Washington, Wyoming

Subject: Physicians are not Providers

Referred to: Reference Committee B

Whereas, the term Provider has increasingly been used more broadly to include physicians; and

Whereas, the term Provider is too inclusive and confuses the Physician Patient relationship; and

Whereas, the term Provider has been utilized as an ambiguous term that inappropriately conflates the credentials, training and experience of separate groups of healthcare professionals; and

Whereas, the American Medical Association has increasing Concerns with scope of practice and has joined lawsuits to preserve the physician role in medicine; and

Whereas, the AMA has existing policy H-405.968 stating that Our American Medical Association supports requiring that health care entities, when using the term “provider” in contracts, advertising and other communications, specify the type of provider being referred to by using the provider’s recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform; and

Whereas, the action items associated with H-405-968 directed our AMA to
1. Consider the generic terms “health care providers” or “provider” as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches.
2. Institute an editorial policy prohibiting the use of the term “provider” in lieu of “physician’ or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and the JAMA Network Journals.
3. Forward to the editorial board of JAMA the recommendation that the term “physician” be use in lieu of “provider” when referring to MD’s and DO’s; and

Whereas, the term provider continues to be the standard term for physicians in healthcare entities; therefore be it

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term “physician” when discussing those with an MD or DO, and either “clinician” or “health care professional” as appropriate to describe those with other varying credentials (Directive to Take Action); and be it further

RESOLVED, that our AMA Oppose the use of the term “provider” when used to include physicians (New HOD Policy); and be it further

RESOLVED, that our AMA evaluate the issue of overbroad terminology using Provider for Physician and others be evaluated for effect on patient education/awareness, transparency and ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RESOLVED, that our AMA refer the issue of “Physicians are not Providers” to the board for study and report back including possible consideration by the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/16/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-26)

Introduced by: International Medical Graduates Section

Subject: Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States

Referred to: Reference Committee B

Whereas, International Medical Graduates (IMGs) constitute a critical component of the United States physician workforce and play an essential role in providing care, particularly in underserved and rural communities[1]; and

Whereas, non-U.S. citizen IMGs frequently rely on non-immigrant visas, including J-1 and H-1B programs, to participate in U.S. graduate medical education and subsequently serve in areas of greatest physician and patient care need[2]; and

Whereas, recent federal actions, including presidential proclamations, have suspended or limited visa issuance and entry for nationals of multiple countries, thereby affecting physicians seeking to enter the United States for residency and fellowship training[3]; and

Whereas, these proclamations apply broadly to individuals outside the United States without valid visas, including fully vetted physicians who have successfully matched into accredited U.S. residency programs and satisfied rigorous screening, credentialing, and licensure requirements[2]; and

Whereas, IMGs undergo extensive vetting through credential verification, standardized examinations, background checks, and institutional review before entering U.S. training programs[4]; and

Whereas, restricting the entry of qualified physicians may disrupt residency training pipelines and adversely affect patient care, particularly in hospitals and communities dependent on IMGs[5]; and

Whereas, the absence or delay of incoming resident physicians may compromise staffing at teaching hospitals, reduce access to care, and exacerbate existing physician shortages[6]; and

Whereas, current proclamations allow for limited case-by-case national interest exceptions but lack clear, consistent, and categorical exemptions for physicians entering the United States to provide essential medical care[3]; and

Whereas, future presidential proclamations or similar federal actions may continue to impose broad entry restrictions without explicit consideration of the essential role of physicians in safeguarding public health[3]; therefore be it

RESOLVED, that our American Medical Association advocate for policies that ensure appropriate consideration and avoidance of undue delays in visa processing, issuance, and entry into the United States for fully vetted international medical graduates entering to

participate in accredited graduate medical education or provide patient care, while maintaining necessary security and vetting procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA monitor and report on the impact of such policies on International Medical Graduate participation, physician workforce supply, patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/16/26

REFERENCES

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4. Intealth / ECFMG. *Certification and Impact of Immigration Policies on International Medical Graduates.* https://www.intealth.org
5. Association of American Medical Colleges (AAMC). *Physician Workforce Data and Projections.* https://www.aamc.org/data-reports/workforce
6. Health Resources and Services Administration (HRSA). *Health Professional Shortage Areas (HPSAs).* https://data.hrsa.gov/topics/health-workforce/shortage-areas

RELEVANT AMA POLICY

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

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the **visa** process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
    c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B **visa** denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Res. 844, I-03 Reaffirmation: A-09 Reaffirmation: I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 312, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-26)

Introduced by: Senior Physicians Section

Subject: Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges

Referred to: Reference Committee B

Whereas, the United States is experiencing a demographic rise in older persons that is creating massive demand for long-term services and supports [LTSS] within the next 10-15 years ["peak demand']; and

Whereas, long-term care, including home- and community-based services (HCBS), are essential to the health and quality of life of older adults and persons with disabilities; and

Whereas, the long-term care workforce has experienced chronic shortages that was markedly exacerbated subsequent to the COVID-19 pandemic; and

Whereas, immigrants represent a substantial share of the direct care workforce in long term care settings, and are disproportionately represented in rural and underserved communities; and

Whereas, in communities where there is a higher proportion of immigrants, there is significant decrease in mortality amongst older people[1,2]; and

Whereas, recent administrative actions affecting immigration enforcement priorities including loss of Temporary Protected Status will significantly adversely affect staffing levels, predictably leading to lower quality of care and excess deaths; and

Whereas, the American Medical Association has long recognized the importance of long-term care, workforce sustainability, and immigration policies that support the health care system [H-280.951]; therefore be it

RESOLVED, that our American Medical Association oppose administrative or regulatory actions that exacerbate staffing shortages or threaten access to long term care when such actions are not accompanied by adequate workforce supply and training, immigration pathways, and funding support (New HOD Policy); and be it further

RESOLVED, that our AMA support immigration policies that protect, retain, and expand the long-term care workforce, including timely work authorization, efficient visa processing, and protections against abrupt workforce disruptions for immigrant health care workers. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/16/26

REFERENCES
David C. Grabowski, Jonathan Gruber, & Brian E. McGarry. "Is Immigration Good for Health? The Effect of Immigration on Older Adult Mortality in the United States." NBER Working Paper 34791, National Bureau of Economic Research, February 2026.
1. National Academies of Sciences, Engineering, and Medicine. (2022). *The National Academies imperative to improve nursing home quality*. https://www.nationalacademies.org/news/2022/the-national-academies-imperative-to-improve-nursing-home-quality.

RELEVANT AMA POLICY

H-440.793 Mass Deportation as a Public Health Issue
1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts.

[Res. 931, I-24]

H-65.932 Reducing the Harmful Impacts of Immigration Status on Health
1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
2. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
3. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.
4. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates.

[Res. 004, A-25]

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.
[Sub. Res.109, A-06; Modified: CMS Rep. 01, A-16]

H-280.945 Financing of Long-Term Services and Supports
1. Our American Medical Association supports policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans.
2. Our AMA supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees.
3. Our AMA supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI.
4. Our AMA supports innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities.
5. Our AMA supports permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy.
6. Our AMA supports Medicare Advantage plans offering LTSS in their benefit packages.
7. Our AMA supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit.
8. Our AMA supports a back-end public catastrophic long-term care insurance program.

9. Our AMA supports incentivizing states to expand the availability of and access to home and community-based services; and
10. Our AMA supports better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

[CMS Rep.05, A-18; Reaffirmed: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 4, I-21; Reaffirmed A-23; Modified: Res. 815, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-26)

Introduced by: Illinois

Subject: Banning Flavored Cannabis E-Cigarettes

Referred to: Reference Committee B

Whereas, vaping e-cigarettes has been a popular form of nicotine and cannabis delivery for approximately twenty years; and

Whereas, on April 2, 2025, the Supreme Court unanimously ruled that the U.S. Food and Drug Administration (FDA) lawfully denied marketing authorization for certain flavored e-liquids used in electronic nicotine delivery systems (ENDS), otherwise known as e-cigarettes (ECIG) or “vapes;” and

Whereas, a recent analysis revealed five clusters of reasons for flavored ECIG use including Increased Satisfaction/Enjoyment, Better Feel/Taste than Cigarettes, Variety/Customization, Food Craving Suppression, and Social Impacts; and

Whereas, flavors may make ECIG use more satisfying and may increase abuse potential, product appeal, and/or reinforcing effects; and

Whereas, cannabis can have a strong, earthy, or even bitter taste, which some users find unpalatable; and

Whereas, flavored cartridges offer a way to mask the unpleasant taste of cannabis, making the vaping experience more pleasant to the user; and

Whereas, flavors in both nicotine and cannabis vape products increased adolescents’ willingness to try them; and

Whereas, cannabis vape products can readily be brought into schools where their use can be very hard to detect; and

Whereas, marijuana vapes use increased by 10.1 percent for 12th grade students, between 2017 and 2023, with just under 20 percent of 12th grade students reported vaping marijuana in 2023; and

Whereas, use of marijuana increased by 5 and 3.5 percent for 10th grade and 8th grade students, respectively, between 2017 and 2023; and

Whereas, approximately one-third (34.5%) of U.S. 12th-grade students who consumed cannabis in 2018 did so by vaping, compared to 19.8 % in 2016; and

Whereas, median maximum concentrations (Cmax) for the cannabis metabolite THCCOOH were qualitatively higher after administration of vaporized cannabis compared to equal doses of smoked cannabis; and

Whereas, National Poison Data System (NPDS) statistics from 2016 through 2023 noted of the 4122 total e-cigarette calls, 1816 (44.1%) were treated at health care facilities (HCF); by comparison, there were 37,971 total tobacco e-cigarette calls of which 7401 (19.5%) were treated at HCF (Chi square with Yates correction two-tailed P value is < 0.0001); and

Whereas, there was an adolescent preponderance of both the flavored (57 adolescents versus 27 adults) and the unflavored calls (44 adolescents versus 33 adult calls); and

Whereas, in the same analysis, toddlers (39.8%) and adolescents (33.4%) trended to be much more prevalent than adults (17.9%) throughout all categories of single exposure cannabis e-cigarette encounters with national poison centers; and

Whereas, a recent meta-analysis which included youth and adult studies reported that among individuals who used cannabis, 22% met criteria for Cannabis Use Disorder (CUD) (95% CI 18%–26%. CUD was most prevalent in young adults, there being among the cohort of cannabis-using 21-year-old emerging adults a very high risk of CUD (41.1%, 95% CI 38.4%–43.8%); and

Whereas, prospective evidence suggests higher potency cannabis which is now exceedingly common (THC content averaging >=12.3%), increases risk for onset of first cannabis use disorder symptom by almost five-fold within the first year of use; and

Whereas, cannabis is a drug with high potential for abuse, particularly in young adults, with use potentially leading to severe psychological or physical dependence and is not a drug with a moderate to low potential for physical and psychological dependence; therefore be it

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling hemp products and public health entities (Directive to Take Action); and be it further

RESOLVED, that our AMA pursue legislative changes concerning a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/18/26

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our American Medical Association believes that cannabis is a dangerous drug and as such is a serious public health concern.

Our AMA believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older.

Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant people, and people who are breastfeeding.

Our AMA believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth.

Our AMA believes laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness.

Our AMA encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency

department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder.
Our AMA supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
Our AMA encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety.
Our AMA encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.
Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.
Our AMA supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities.
Our AMA will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-26)

Introduced by: Illinois Delegation

Subject: Banning Synthesized, Purified or Derivative Products from Kratom

Referred to: Reference Committee B

Whereas, kratom (Mitragyna speciosa) is a plant indigenous to Southeast Asia, typically consumed by tea or powder, with physiologic effects like opioids, as well as stimulants. There is an increasing prevalence of kratom use, raising concern for possible dependence, addiction, and toxicity; and

Whereas, an estimated 1.7 million Americans aged 12 and older used kratom in 2021, according to the Substance Abuse and Mental Health Services Administration; and

Whereas, a recent cross-sectional survey utilizing a non-probabilistic nationally representative sampling with a total of 11,545 respondents of which 1,049 reported current kratom use, indicating a 9.1% prevalence. The most common kratom products used in the past 30 days were pills, gummies and powder formulations. A higher incidence of adverse effects was reported as the amount of kratom per dose increased with gummies/capsules/tablets/pills; and

Whereas, in a recent study of secret shopper visits were conducted at 100 San Antonio and Austin, Texas smoke shops. kratom (94%) was routinely stocked by smoke shops. When specifically asked about adverse effects, 24% of smoke shop employees did not disclose any risks about kratom; most others provided minimal information; and

Whereas, kratom has only four known pharmacologically active compounds. Of these active compounds, mitragynine is the most prevalent, but 7-OH-mitragynine is more pharmacologically active; and

Whereas, mitragynine toxicity can cause a range of adverse effects, including organ damage, seizures, and respiratory depression, particularly at high doses. The risk is significantly heightened when mitragynine, a major psychoactive compound in kratom, is taken in combination with other drugs; and

Whereas, a study by the National Poison Data system (NPDS) in 2019 found that the most common presenting symptoms after kratom ingestion included agitation, tachycardia, drowsiness, and confusion; and

Whereas, mitragynine poses a risk to recreational users and those using it as a natural remedy or nutritional supplement due to lack of medical supervision or oversight/regulation; and

Whereas, although the alkaloid content naturally ranges from 2 to 6% in native leaf material, it can be up to 60% in concentrated extracts; and

Whereas, 7-hydroxymitragynine (7-OH) is a naturally occurring alkaloid in the kratom plant, but only a minor constituent that comprises less than 2% of the total alkaloid content in natural

kratom leaves. However, 7-OH demonstrates substantially greater mu-opioid receptor potency (a compound 5–20 times more potent than mitragynine and an estimated 13 times more potent than morphine) than kratom's primary alkaloid constituent mitragynine; and

Whereas, in the current marketplace in the U.S., 7-OH is increasingly being marketed over the counter and online, in concentrated forms or sufficient doses to cause harms to those individuals engaging, knowingly or unknowingly, in use of 7-OH; and

Whereas, the availability of 7-OH products is a major concern to the FDA, as consumers can easily purchase products with concentrated levels of 7-OH online and in gas stations, corner stores and vape shops. The FDA is particularly concerned with the growing market for 7-OH products that may be especially appealing to children and teenagers, such as fruit-flavored gummies and ice cream cones. These products may not be clearly or accurately labeled as to their 7-OH content and are sometimes disguised or marketed as kratom; and

Whereas, there are no FDA-approved products containing 7-OH; and

Whereas, in June 2025, the FDA issued warning letters to seven companies for illegally distributing products containing 7-OH, including tablets, gummies, drink mixes and shots; and

Whereas, in 2021, the NPDS included 1,524 kratom case mentions. Of those, 948 were single exposure reports, of which 67 were associated with major medical outcomes and four associated deaths; and

Whereas, according to recent NPDS data (reporting period: 2/1/2025-4/30/2025); there were a total of 53 exposure cases involving 7-OH during this period, the majority of which involved abuse related reasons for use (i.e., "intentional abuse"). Most single-substance 7-OH exposure cases resulted in minor or moderate clinical outcomes, with several documented having major clinical outcomes; and

Whereas, forty cases of death by mitragynine were identified from the Medical Examiners in Florida over a five-year period while the L.A. County medical examiner has reported six overdose deaths in LA County residents between the ages of 18 to 40 years old in the first ten months of 2025 as involving 7-OH; and

Whereas, analysis of kratom and its analogues (particularly mitragynine and 7-OH-mitragynine) in urine or blood are not available at any hospital based clinical chemistry laboratory; and

Whereas, kratom products do not meet basic quality control standards for purity analysis, product constituent levels, standard labeling and accurate warnings to ensure public education and safety; and

Whereas, among the southeast Asian countries, Malaysia, Myanmar, and Singapore consider the kratom plant, mitragynine, and 7-hydroxymitragynine (7-OH) as prohibited from consumption, possession, and trade; and

Whereas, medicinal chemistry efforts have led to synthetic 7-OH derivatives such as MGM-15, where stereospecific saturation of the imine N (1)–C (2) double bond increases opioid receptor affinity and activity. Despite its higher in vitro opioid potency, MGM-15 is currently sold in the US for human consumption as a "research chemical" in tablet form, even though there is an absence of this being studied in humans and obviously no FDA approval. MGM-15 shows

greater opioid receptor binding affinities than 7-OH, indicating the potential for higher opioid effects and risks; and

Whereas, these unregulated products are packaged in a way to market themselves to minors; these products have no minimum purchase age, nor do they require an ID check for age verification. In addition, many of these retailers have shops that are close to school grounds, playgrounds, and other public places that are widely accessible to minors; therefore be it

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/18/26

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RELEVANT AMA POLICY

Regulate Kratom and Ban Over-the-Counter Sales H-95.903

1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials, and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.

2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.

Res. 515, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-26)

Introduced by: International College of Surgeons

Subject: Physician Unity in Advocacy Regarding Physician Reimbursement

Referred to: Reference Committee B

Whereas, the American Medical Association (AMA) House of Delegates serves as the principal policy-making body representing physicians across specialties and practice settings in the United States; and

Whereas, physician payment systems under the Medicare Physician Fee Schedule operate under statutory budget neutrality requirements, which often result in reductions in reimbursement to some physician services when increases occur elsewhere; and

Whereas, AMA policy D-400.982, “AMA Efforts on Physician Payment Reform,” recognizes that instability and reductions in physician reimbursement threaten the sustainability of medical practice and patient access to care; and; AMA policy H-400.972, “Physician Payment Reform,” supports stable and predictable payment updates to protect physician practices and maintain patient access to physician services; and

Whereas, AMA policy H-390.849, “Principles for Physician Payment Reform,” affirms that physician payment systems should ensure adequate reimbursement for physician services and promote access to high-quality care; and; AMA policy H-450.947, “Pay-for-Performance Principles and Guidelines,” emphasizes that physician payment reforms should avoid unintended consequences that undermine the delivery of patient care; and Advocacy by one physician specialty or physician organization for reductions in reimbursement directed toward another physician specialty risks undermining physician unity and may contribute to policies that weaken the physician workforce and reduce patient access to care; therefore be it

RESOLVED, that our American Medical Association reaffirm that physician payment reform should prioritize the sustainability of the entire physician workforce and the protection of patient access to care (New Hod Policy); and be it further

RESOLVED, that our AMA adopt policy stating that physicians and physician organizations should refrain from advocating for reductions in reimbursement specifically targeted at other physician specialties or physician groups (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician organizations to pursue payment reform through approaches that improve overall fairness, adequacy, and stability of physician reimbursement rather than redistribution among physician specialties (Directive to Take Action); and be it further

RESOLVED, that our AMA affirm that physicians should advocate collectively against reimbursement cuts affecting any group of physicians and support efforts to protect the financial sustainability of all physician practices in order to preserve patient access to care. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/19/26

RELEVANT AMA POLICY

D-400.982 AMA Efforts on Medicare Payment Reform
Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases. BOT Rep. 12, A-24Reaffirmed: Res. 220, I-24

H-400.972 Physician Payment Reform
It is the policy of our American Medical Assoication to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS Sub. Res. 109, A-92Reaffirmed: I-92Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95Reaffirmation A-99 and Reaffirmed: Res. 127, A-99Reaffirmation A-02Reaffirmation A-06Reaffirmation I-07Reaffirmed: BOT Rep. 14, A-08Reaffirmation A-09Reaffirmed: CMS Rep. 01, A-19Reaffirmed: Res. 212, I-21Reaffirmed: Res. 802, I-24

H-390.849 Physician Payment Reform
Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles: Promote improved patient access to high-quality, cost-effective care. Be designed with input from the physician community. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions. Not require budget neutrality within Medicare Part B. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice. CMS Rep. 6, A-09Reaffirmation A-10Appended: Res. 829, I-10Appended: CMS Rep. 1, A-11Appended: CMS Rep. 4, A-11Reaffirmed in lieu of Res. 119, A-12Reaffirmed in lieu of Res. 122, A-12Modified: CMS Rep. 6, A-13Reaffirmation I-15Reaffirmation: A-16Reaffirmed in lieu of: Res. 712, A-17Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17Reaffirmation: A-19Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Reaffirmed: Res. 212, I-21Reaffirmed: Res. 240, A-22Reaffirmation: A-22Modified: CMS Rep. 04, A-23Reaffirmed: Res. 214, A-23Reaffirmation: A-23Reaffirmed in lieu of: Res. 225, A-25Reaffirmed: Res. 226, A-25

H-450.947 Pay-for-Performance Principles and Guidelines
Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." BOT Rep. 5, A-05Reaffirmation A-06Reaffirmed: Res. 210, A-06Reaffirmed in lieu of Res. 215, A-06Reaffirmed in lieu of Res. 226, A-06Reaffirmation I-06Reaffirmation A-07Reaffirmation A-09Reaffirmed: BOT Rep. 18, A-09Reaffirmed in lieu of Res. 808, I-10Modified: BOT Rep. 8, I-11Reaffirmed: Sub. Res. 226, I-13Appended: BOT Rep. 1, I-14Reaffirmed in lieu of Res. 203, I-15Reaffirmed in lieu of Res. 216, I-15Reaffirmation I-15Reaffirmed: BOT Rep. 20, A-16Reaffirmed in lieu of: Res. 712, A-17Reaffirmation: A-18Reaffirmation: A-22Reaffirmed: CMS Rep. 07, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities

Referred to: Reference Committee B

Whereas, United States Immigration and Customs Enforcement's (ICE) Enforcement and Removal Operations (ERO) officers are given the authority to enforce immigration laws within the interior through the arrest, detention, and removal of undocumented individuals with the stated purpose of protecting national security and public safety;[1] and

Whereas, immigration detention is civil custody, not criminal incarceration, yet ICE and contract facilities use criminal detention infrastructures, despite 41,589 out of 58,766, (70.8%) of detainees at immigration detention centers holding no criminal convictions, creating gray areas that allow facilities to bypass health protections;[2,3] and

Whereas, the number of people detained by ICE rose from 39,587 on January 19, 2025, to 58,766 on September 7, 2025, nationwide reflecting a rapid escalation in immigration detention practices;[4,5] and

Whereas, immigration detention centers comprise a variety of facilities in order to detain noncitizens of the United States, including county jails, state and federal prisons, private detention centers, hotels, and even federal office buildings but most individuals detained by ICE are imprisoned in facilities that are either owned or run by private or for-profit prison companies;[6-8] and

Whereas, the National Standards on Transport, Escort, Detention, and Search (TEDS) has created guidelines to ensure individuals in immigration detention centers receive basic necessities, such as hygiene, food and water, and medical care; however, individuals have experienced poor conditions such as cold temperatures, lack of medical care, and inadequate food with minimal religious dietary accommodations;[6] and

Whereas, 42.5% of individuals in immigration detention centers have at least one chronic medical condition, underscoring the elevated need for continuous care, particularly given the average detention stay of 421 days; yet, many detainees report significant disruptions in care, including delays in treatment, medication interruptions, denial of language interpretation services, and lack of follow-up for chronic illnesses;[9-10] and

Whereas, between 2018 and 2019, nearly 900 detainees across 57 ICE detention facilities in 19 states were infected during a mumps outbreak, illustrating inadequate infection control measures;[11] and

Whereas, independent reviews of 52 deaths in ICE custody between 2017 and 2021 found that 95% were preventable with adequate medical care, underscoring systemic failures in clinical oversight, chronic disease management, and emergency response protocols;[12] and

Whereas, during investigations of deaths during ICE detainment, ICE allowed facilities to destroy evidence, omit inculpatory facts, fail to interview key witnesses, and lack a standardized criteria for autopsies;[12] and

Whereas, there has been a documented elevenfold increase in suicide rates and preventable deaths in ICE custody, with the death rate in immigration facilities within the first six months of 2025 being the highest rate of any publicly available year, attributed to systemic failures in mental health care, solitary confinement practices, and inadequate medical evaluation protocols;[9,13-15] and

Whereas, oversight mechanisms remain inadequate as the Office of Detention Oversight (ODO) only conducts 25% of inspections, with other inspections done privately or as self-assessments, and private entities identify less than half of the deficiencies identified by (ODO), are criticized as superficial and ineffective, and ICE personnel report that inspectors frequently conduct only perfunctory reviews of standards;[17, 19-21] and

Whereas, comprehensive inspections conducted by ODO occur only once every three years on average, allowing documented violations, such as inadequate medical care, suicide risk, mismanagement, and unreported abuse, to persist without timely corrective action;[20,22-24] and

Whereas, ICE facilities continue to rely on pre-announced inspections, often only every three years, and are frequently granted waivers that allow facilities to bypass critical health and safety standards outlined by the National Detention Standards, ranging from waivers allowing strip searches to those exempting facilities from complying with fire prevention standards;[21-24] and

Whereas, when faced with knowledge of over 14,000 deficiencies in adherence to procedures at 106 contract facilities, including those that put the health and safety of detainees at risk, ICE only imposed financial penalties on two instances and issued waivers at other facilities;[17] and

Whereas, ICE has no formal policies or procedures in place to guide the waiver process and has allowed Enforcement and Removal Operations (ERO) officers to grant waivers without clear authority to do so, causing only 3 waivers in a sample of 65 to have an expiration date, meaning many facilities may permanently avoid compliance;[17,22] and

Whereas, in light of the persistent use of detention facilities, it remains an ethical and public health imperative to ensure that detained individuals receive humane, timely, and appropriate medical and mental health care, to the fullest extent possible, as an interim measure of health accountability;[23-25] and

Whereas, evidence from carceral health systems shows that independent, transparent, and frequent reporting of health metrics, particularly when conducted by external monitors and publicly disclosed, can improve care quality, and that carefully structured financial incentives tied to health outcomes may further encourage high standards of care in immigration detention facilities;[26-28] therefore be it

RESOLVED, that our American Medical Association support independent, transparent, unannounced inspections of all ICE detention facilities, with anti-retaliation protections for detainees and health staff who participate (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to reform ICE’s waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

D-350.983 Improving Medical Care in Immigrant Detention Centers
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

H-350.957 Addressing immigrant health disparities
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health, and supports legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. 3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient-centered, language and culturally appropriate way upon presentation for asylum, regardless of country of origin. 4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers. 5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers. 6. Our AMA urges physicians to provide medically appropriate care for asylum seekers. 7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services. 8. Our AMA encourages the provision of resources to assist people seeking asylum, including social and legal services. [Res. 804, I-09Appended: Res. 409, A-Reaffirmation: A-19Appended: Res. 423, A-19 Reaffirmation: I-19Modified: BOT Rep. 08, I-24]

H-65.934 Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
1. Our American Medical Association opposes the relocation of migrants and asylum-seekers by state or federal authorities without timely and appropriate resources to meet travelers' needs, especially when deceptive or coercive practices are used.
2. Our AMA supports state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations.

[Res. 006, I-24]

H-65.938 Guiding principles for the health care of migrants
1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement.”
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants’ health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing

mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.

6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
    a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
    b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
    c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
    d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
    e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

[Res. 016, A-24]

H-406.987 Medical Information and its uses

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients, and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices. Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information. Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts. Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive

use of health care data. Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete. Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages the use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter. Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used. Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement. Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility, and reduce barriers that currently limit access to and use of the health care data. Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats. Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary. Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s), as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused on the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15Reaffirmation: I-18Reaffirmed: CSAPH Rep. 2, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-26)

Introduced by: LGBTQ+ Section, Medical Student Section, American College of Physicians

Subject: Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care

Referred to: Reference Committee B

Whereas, AMA Policy G-605.009 established the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to guide organized medicine's response to restrictions on evidence-based care and to create implementation-focused advocacy and practice resources; and

Whereas, Policy G-605.009 explicitly anticipates and prepares for bans on other appropriate health care, including gender-affirming care, and calls for identification of information and resource gaps and the creation of implementation blueprints to mitigate harm; and

Whereas, the Task Force has demonstrated effectiveness in developing implementation tools, including landscape analyses, litigation monitoring, partnership with legal defense networks, physician education, and creation of the Reproductive Health Resource Navigator as a centralized digital resource hub[1]; and

Whereas, restrictions on gender-affirming care have proliferated in multiple jurisdictions and across numerous levels of government and regulatory agencies, creating significant legal uncertainty, regulatory confusion, reimbursement barriers, institutional policy variability, and potential civil, criminal, and professional liability risk for physicians[2-4]; and

Whereas, medical students, residents, and fellows in states with restrictions face diminished training opportunities in gender-affirming care, threatening workforce preparedness and future access to appropriate and evidence-based care, with resultant decreased physician workforce in such restricted states[4-6]; and

Whereas, physicians require centralized, up-to-date, practical guidance addressing evolving statutory restrictions, shield laws, privacy protections, telehealth considerations, interstate licensure, documentation standards, payer policies, institutional risk mitigation, and medical liability concerns; and

Whereas, gender-affirming care is multi-specialty care, positioning the AMA as an effective convener of representatives across specialties to facilitate collaborative efforts[7]; and

Whereas, organized medicine has an ethical obligation to defend the patient-physician relationship and ensure that physicians can provide evidence-based, patient-centered care without undue interference; therefore be it

RESOLVED, that our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care

Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:

1. State-specific legal summaries and regulatory guidance;
2. Shield law analyses and cross-state practice considerations;
3. Privacy and HIPAA compliance best practices;
4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
5. Documentation and informed consent templates consistent with evolving legal standards;
6. Coding, billing, and reimbursement guidance;
7. Institutional policy templates and sample protocols;
8. Educational and training resources for undergraduate and graduate medical education;
9. Telehealth and interstate licensure guidance; and
10. Information regarding legal assistance and physician defense resources (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient-physician relationship, with guidance by the Task Force (Directive to Take Action); and be it further

RESOLVED, that our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report annually to the House of Delegates regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes. (Directive to Take Action)

Fiscal Note: Major – To Be Determined

Received: 4/20/26

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RELEVANT AMA POLICY

G-605.009 Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.
[Res. 621, A-22 Appended: Res. 816, I-23 Appended: Res. 207, I-24]

D-605.982 Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.
[Res. 207, I-24]

D-5.998 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
1. Our American Medical Association Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.
2. Our AMA will work to facilitate support, including legal support through the AMA Litigation Center, as may be appropriate, to physicians that are targeted for practicing in accordance with accepted standards of medical care and medical ethics in the face of legal constraint or any other disciplinary action.
3. Our AMA will advocate for affirmative protections for "conscientious provision" of care in accordance with accepted standards of medical care and medical ethics in hostile environments on par with protection of "conscientious objection."
[Res. 008, I-22 Reaffirmation: A-23]

H-275.937 Patient/Physician Relationship and Medical Licensing Boards
Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations:
1. Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are:
a. open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in their care;
b. commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests;
c. provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less; and
d. avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.
2. The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.
3. Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.
4. The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.
5. A (name of state) physician has both medical-legal and ethical obligations to their patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients.
[BOT Rep. 30, I-98 Reaffirmed: CME Rep. 2, A-08 Modified: CME Rep. 01, A-18 Modified: Speakers Rep. 02, I-24]

D-275.942 Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care
1. Our American Medical Association advocates that no physician be disqualified from medical licensure or subject to unnecessary delay in the licensure process solely due to having provided abortion care or gender-affirming care in accordance with then-current standards of medical practice and/or while such care was legal in their jurisdiction.

2. Our AMA supports policies, legislation, and state medical society initiatives that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care.
3. Our AMA will work with relevant interested parties, including state medical boards and specialty societies, to support the development of guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming. [Res. 231, I-25]

H-65.964 Access to Basic Human Services for Transgender Individuals
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity. [Res. 010, A-17]

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations. [CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24 Appended: Res. 413, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-26)

Introduced by: Texas

Subject: Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan

Referred to: Reference Committee B

Whereas, the $35 cap on insulin copays only applies to specific brand or version on a plan's formulary; and

Whereas, although plan formularies are available online in real-time, accurate information can be delayed or unavailable, especially during a plan change; and

Whereas, timely access to insulin is required to prevent acute decompensation of diabetes; therefore be it

RESOLVED, that our American Medical Association adopt as policy and advocate that beneficiaries of ERISA-governed health plans be allowed a 30-day transition fill of insulin at the beginning of each plan year to allow time for the formulary preference to be determined by the patient and prescriber. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/20/26

RELEVANT AMA POLICY

H-100.964 Drug Issues in Health System Reform
1. Our American Medical Association consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
2. Our AMA supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
3. Our AMA reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
4. Our AMA supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
5. Our aMA supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
6. Our AMA encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
a. Our AMA encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of

medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
7. Our AMA reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.

H-110.984 Insulin Affordability

1. Our American Medical Association will encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate.
2. Our AMA supports initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
3. Our AMA supports state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-26)

Introduced by: Texas

Subject: Prohibiting the Independent Practice of Medicine by Artificial Intelligence

Referred to: Reference Committee B

Whereas, artificial intelligence (AI) is a powerful tool in augmenting the delivery of high quality health care and in expanding access to care in rural and underserved areas; and

Whereas, AI can enhance diagnostic capabilities and help with remote patient monitoring and automation of administrative tasks; and

Whereas, AI can provide accessible health education to patients through online platforms and apps; and

Whereas, AI can assist primary care physicians by collecting data regarding rural care for analysis, and evaluating large datasets to enhance care approaching levels similar to urban centers; and

Whereas, the “Healthy Technology Act of 2025” (H.R. 238) has been introduced in the U.S. House of Representatives to explore the possibility of allowing FDA approved AI to prescribe drugs; and

Whereas, H.R. 238 asks that AI be authorized by state law; and

Whereas, the One Big Beautiful Bill House version approved a 10-year moratorium on state AI legislation that was not passed by the Senate; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and regulation prohibiting the use of artificial intelligence (AI) as an independent diagnostic or prescriptive tool or as a care management substitute for a physician. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

RELEVANT AMA POLICY

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954

1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
    a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
    b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
    c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
    d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
2. Our AMA will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight.

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-26)

Introduced by: American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Medicare Administrative Contractor Policy Modification

Referred to: Reference Committee B

Whereas, recent Local Coverage Determination (LCD) proposals have called for drastic changes in Medicare coverage for botulinum toxin injections for spasticity and for peripheral nerve blocks; and

Whereas, the comment period for new or revised LCDs is only 45 days, which does not provide sufficient time to develop a robust response given the scope and breadth of most LCDs and Medicare Administrative Contractors (MACs) requests for detailed references and objective data to be submitted with any comments; and

Whereas, these LCDs are lengthy with tremendous breadth and include a variety of procedures, and a comprehensive literature review of potential impacts takes more time to assemble; and

Whereas, more time would allow specialty societies to engage their subject matter experts and work collaboratively; and

Whereas, the Billing and Coding Local Coverage Article (LCA) that accompanied a recent botulinum toxin LCD took effect despite concerns raised by specialty societies and inadvertently eliminated coverage for diagnostic codes including quadriplegia, paraplegia, and monoplegia because they did not contain the word "spastic" in the code's descriptor, and there was not a separate ICD10 code for spasticity (until a formal reconsideration resulted in a revised policy); and

Whereas, the MAC’s initial decision regarding botulinum toxin injections caused delays in care for patients with spasticity due to spinal cord injury which adversely affected their medical care and function; and

Whereas, the MAC’s proposed LCD on peripheral nerve blocks will adversely affect patients with chronic pain who get relief from the injections rather than chronic opioids; therefore be it

RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read:

1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.
2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from

being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.
3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.
4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs.
5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function.
6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process. (Reaffirm HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

RELEVANT AMA POLICY

D-330.918 Appropriateness of National Coverage Decisions
1. Our American Medical Association will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care.
2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice.

D-330.897 Stakeholder Engagement in Medicare Administrative Contractor Policy Processes
1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.
2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.
3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and

advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.

D-330.908 Improving the Local Coverage Determination Process
1. Our AMA will advocate through legislative and/or regulatory efforts as follows:
A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD;
B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.
2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to:
A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Ending Private Equity Dividend Recapitalization in Healthcare

Referred to: Reference Committee B

Whereas, AMA Policy D-160.904, which states: “Our American Medical Association will propose appropriate guidelines for the use of private equity (PE) in health care, ensuring that physician autonomy and operational authority in clinical care are preserved and protected”; and

Whereas, “Private equity” is an asset class that invests capital directly into private companies not listed on public stock exchanges. PE firms typically raise, buy, restructure, and extract profit from acquired businesses, aiming to sell them for a profit after a limited number of years, such that profit generation becomes a higher priority than excellent service delivery; and

Whereas, increasing numbers of physician practices, hospitals, and other enterprises that provide health care are being purchased by PE corporations, such that within the past decade, PE corporations have invested more than $1 trillion into health care acquisitions, including at least 17% of Urgent Care Centers and between 25-40% of Emergency Departments[1]; and

Whereas, a key component of the business model which PE firms utilize when they extract profits from health care enterprises that they acquire involves the practice of “Dividend Recapitalization”, a financial strategy by which a PE company purposefully takes on new debt to enable payment of an immediate special dividend to its shareholders; and

Whereas, for Dividend Recapitalization to enable this special dividend, a PE corporation borrows funds, usually through a new loan issued from syndicated leveraged loan markets, or by the issuing of corporate bonds. Whether raised by a new loan or a bond issue, this source of funds is then used to pay the large, one-time dividend to shareholders noted above. This process simultaneously increases the acquired enterprise's debt and reduces its equity[2], posing new financial challenges to previously existing and ongoing health care clinical operations; and

Whereas, to issue a dividend upon acquisition of a corporation by a PE firm, as is done via “dividend recapitalization”, violates typical capitalistic practices, because in capitalist economies, dividends are typically declared only after a corporation generates profits from its operations; and

Whereas, to enable a PE-acquired health care enterprise to retire the debt acquired to enable the practice of Dividend Recapitalization, saddles the acquired enterprise with new debt, and this debt forces service cutbacks and staffing limitations after PE acquisition, direct consequences of reduced equity and increased debt imposed upon the acquired health care enterprise; and

Whereas, private equity acquisition of physician practices has been associated with increased physician turnover and workforce instability, reflecting reduced physician morale and burnout-related pressures[3], and has also been associated with increased health care spending and higher prices charged to patients following acquisition[4]; and

Whereas, typically PE firms cut staffing, equipment, and services, with these staff and service cutbacks associated with patient harms, such as increased death rates[5]; and

Whereas, these changes made consequent to a dividend recapitalization would not have been advocated by physicians working within the PE-acquired health care enterprise, demonstrating that the requirement to repay this dividend impairs physician autonomy and authority, in direct violation of AMA Policy D-160.904; therefore be it

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors (Directive to Take Action); and be it further

RESOLVED, that our AMA will develop model federal and state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. Health Affairs. The influence of private equity in health care. Issued October 22, 2025. https://www.healthaffairs.org/do/10.1377/hpb20251007.715449/ Accessed March 16, 2026
2. Dividend recapitalization. Moonfare, November 28, 2025. https://www.moonfare.com/glossary/dividend-recapitalization Accessed March 16, 2026
3. Singh Y, Bejarano Cardenas G, Torabzadeh H, et al. Physician turnover increased in private equity-acquired physician practices. Health Affairs. 2025;44(3):280-287.
4. Braun RT, Bond AM, Qian Y, et al. Association of private equity acquisition of physician practices with changes in health care spending and utilization. JAMA Health Forum. 2022;3(9):e222886.
5. Kannan S, Dov Bruch J, Zubizarreta JR. Hospital staffing and patient outcomes after private equity acquisition. Ann Intern Med. 2025;178:1529-38.

RELEVANT AMA POLICY

AMA Policy D-160.904 The Regulation of Private Equity in the Healthcare Sector
Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-26)

Introduced by: American Academy of Emergency Medicine, Florida

Subject: Strengthening Our AMA Efforts Toward CPOM Prohibition

Referred to: Reference Committee B

Whereas, AMA Policy H-215.981, Corporate Practice of Medicine, states that the AMA opposes the corporate practice of medicine, supports restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups, and supports model legislation to protect physician autonomy and patient-centered care; and

Whereas, AMA Policy H-160.887 recognizes that the corporate practice of medicine can erode the patient-physician relationship and create conflicts between investor profit motives and the ethical practice of medicine; and

Whereas, AMA Policy H-160.891, Corporate Investors and Other Corporate Entities, addresses physician relationships with corporate investors but does not clearly prohibit ownership and governance structures that allow non-licensed entities to exercise control over clinical practice; and

Whereas, AMA Code of Medical Ethics Opinion 11.2.3, Contracts to Deliver Health Care Services, states that contracts must not compromise physicians' professional judgment, clinical autonomy, or patient welfare, and that physicians must not enter agreements that prioritize financial interests over patient care; and

Whereas, Vermont House Bill H.583 (2026)[1] would strengthen restrictions on the corporate practice of medicine by prohibiting unlicensed entities from owning medical practices, requiring that licensed physicians hold majority ownership and voting control of professional medical corporations, and barring corporate interference in clinical decision making; and

Whereas, Oregon Senate Bill 951 (2025)[2] strengthens the prohibition against the corporate practice of medicine doctrine by restricting management service organizations and their affiliates from owning or exercising de facto control over physician practice entities, and by prohibiting interference with physician clinical judgment, staffing, compensation, coding, billing, contracting, and other operational decisions that affect patient care; and

Whereas, these legislative efforts reflect a growing recognition that corporate ownership models and management structures can undermine physician autonomy, distort clinical priorities, and compromise patient trust; and

Whereas, stronger and more precise AMA policy guidance is needed to align with emerging state laws and to clearly define and restrict corporate practice arrangements that allow non-licensed entities to control or influence medical decision making; therefore be it

RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in section 1 as follows:

"1. Our American Medical Association ~~encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under 'friendly' physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:~~ supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in the introductory clause preceding subsections (a)–(c) as follows:
"~~Physicians who are contemplating corporate investor partnerships or corporate entity relationships~~ Physicians and policymakers evaluating corporate investment in physician practices should consider the following principles to ensure that any such relationships remain subordinate to physician ownership, governance, and professional medical judgment" (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (d) as follows:
"(d) ~~Physicians should ensure that contractual arrangements preserve physician autonomy in clinical decision making.~~Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (e) as follows:
"(e) ~~Physicians should carefully review contractual provisions governing governance structures, compensation arrangements, and management responsibilities when entering relationships with corporate investors.~~ Our AMA opposes stock transfer restriction agreements, "friendly PC" arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians' professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (f) to read as follows, and renumbering the subsequent subsections accordingly:
"(f) Our AMA opposes management services organizations, private equity firms, and other non-licensed entities, and their owners, officers, directors, employees, or agents, from exercising governance authority or management control within a professional medical entity in a manner that directs, controls, or unduly influences clinical decision making, physician employment conditions affecting patient care, or other decisions reserved to licensed physicians." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (g) to read as follows, and renumbering the subsequent subsections accordingly:
"(g) Our AMA opposes noncompetition, nondisclosure, non-disparagement, and non-interference clauses that restrict a physician's ability to exercise independent professional

judgment, advocate for patients, report unsafe or unethical conditions, or continue caring for patients consistent with ethical and legal obligations." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (h) as follows:
"(h) ~~Physicians should seek transparency regarding the financial and ownership structures associated with corporate investors and related entities.~~ Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity." (Modify Current HOD Policy); and be it further

RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in item 2 as follows:
"2. Physicians should understand and evaluate the financial and governance implications of corporate investment in medical practices ~~before entering such arrangements~~ and ensure that any such arrangements do not transfer ownership, governance authority, or operational control over clinical decision making to non-licensed entities." (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/20/26

REFERENCES

1. Vermont House Bill 583 2026. https://legislature.vermont.gov/Documents/2026/Docs/BILLS/H-0583/H-0583%20As%20Introduced.pdf
2. Oregon Senate Bill 951 2025. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB951/Enrolled

RELEVANT AMA POLICY

AMA Policy H-215.981, Corporate Practice of Medicine

1. Our AMA vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts ofinterest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

AMA Policy H-160.891 Corporate Investors and Other Corporate Entities

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
    d. Retaining negotiators to advocate for the best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
    h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
    j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
        i. Determining which diagnostic tests are appropriate;
        ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
        iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
        iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
        v. Determining the content of patient medical records;
        vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
        vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
        viii. Making decisions regarding coding and billing procedures for patient care services; and
        ix. Approving the selection of medical equipment and medical supplies.
    k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision ofnon- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

AMA Policy H-160.887 Corporate Practice of Medicine
Our American Medical Association acknowledges that the corporate practice of medicine:

1. has the potential to erode the patient-physician relationship.

2. may create a conflict of interest between profit and best practices in residency and fellowship training.

AMA Code of Medical Ethics 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;
(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 togood 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Reducing Emergency Department Boarding through Payment Reform

Referred to: Reference Committee B

Whereas, our AMA Policy D-130.957, Addressing and Reducing Patient Boarding in Emergency Departments, recognizes that boarding patients in the emergency department harms patient safety and quality of care but lacks strong mechanisms to support system change; and

Whereas, boarding of admitted patients in emergency departments delays definitive care, contributes to clinical deterioration, increases medical error risk, reduces throughput capacity, and worsens clinician burnout and system inefficiency; and national clinical guidance identifies boarding times beyond four hours as associated with adverse outcomes[1-4]; and

Whereas, from a systems perspective, emergency department boarding follows surges in inpatient demand, yet hospital leaders continue to manage their systems by using the emergency department as the system's only "surge absorber", even though other resources to dissipate surge have been described and advocated in peer-reviewed literature[5-7]; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) released updated Hospital Outpatient Prospective Payment System quality reporting requirements that include emergency care abstracted clinical quality measures such as median time from ED arrival to departure, initially voluntary with planned transition to mandatory reporting, but do not currently include any payment consequence tied to prolonged boarding times; and reporting of these measures does not itself create financial incentives for hospitals to act[1]; and

Whereas, current reimbursement structures do not adequately incentivize hospitals to reduce boarding, despite evidence that operational inefficiencies and boarding increase costs and strain resources without improving care quality[2,3]; and

Whereas, aligning financial incentives with quality outcomes through payment reform is a proven strategy to motivate system improvement and hold institutions accountable for key safety and access metrics; therefore be it

RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further

RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequence. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final Rule. Federal Register. Published November 25, 2025.
2. American College of Emergency Physicians. Emergency Department Crowding and Boarding. Ann Emerg Med. Various publications summarizing boarding >4 hours as a quality concern.
3. Office of Inspector General, U.S. Department of Health and Human Services. Hospital Emergency Department Crowding and Boarding of Admitted Patients. OEI-02-21-00320. Published 2022.
4. Agency for Healthcare Research and Quality. Emergency Department Crowding and Patient Safety. AHRQ Publication.
5. Viccellio, P., et al. Patients Overwhelmingly Prefer Inpatient Boarding to Emergency Department Boarding. Journal of Emergency Medicine. Volume 45, Issue 6, P942-946. December 2013. https://www.jem-journal.com/article/S0736-4679(13)00826-3/abstract
6. Litvak E, Bisognano M. More patients, less payment: increasing hospital efficiency in the aftermath of health reform. Health Aff (Millwood). 2011;30(1):76-80.
7. Hoot NR, Aronsky D. Systematic review of emergency department crowding: causes, effects, and solutions. Ann Emerg Med. 2008;52(2):126-136.

RELEVANT AMA POLICY

D-130.957 Addressing and Reducing Patient Boarding in Emergency Departments

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-26)

Introduced by: Association for Clinical Oncology, American Society of Hematology

Subject: Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions

Referred to: Reference Committee B

Whereas, federal mandates under Public Law No. 119-21 (the enacted version of H.R. 1) require the District of Columbia and the 40 states that have expanded Medicaid to implement community engagement or work requirements by January 1, 2027; and

Whereas, our American Medical Association's (AMA) Policy H-290.963 supports robust exemptions for individuals who are "medically frail" or have "serious or complex medical conditions," yet these terms lack a uniform clinical definition across the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies; and

Whereas, our AMA has advocated for federal and state policies that protect vulnerable populations, specifically urging CMS to ensure that mandatory 'medical frailty' exemptions include individuals with cancer, heart disease, or other chronic and severe conditions to prevent them from falling through the cracks of new community engagement requirements; and

Whereas, Public Law No. 119-21 defines an individual who is "medically frail or otherwise has special medical needs (as defined by the Secretary)" as one who is "blind or disabled (as defined in section 1614); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual, or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or with a serious or complex medical condition"; and

Whereas, the absence of explicit exemption language across Medicaid programs creates administrative barriers that jeopardize coverage for patients in critical phases of care, such as diagnostic testing, active treatment, long-term surveillance or monitoring, and survivorship; and

Whereas, patients living with complex medical conditions—including but not limited to cancer, end-stage renal disease, advanced cardiovascular disease, and other conditions across medical, surgical, and psychiatric domains—face intense treatment regimens and physical limitations that make meeting work requirements both practically unfeasible and a risk to their health; and

Whereas, a patient's recovery and stability often rest on the shoulders of a primary caregiver, whose vital role is undermined when work mandates threaten the caregiver's own health coverage and the stability of the household; and

Whereas, moreover, the absence of clear, standardized exemption criteria may compel physicians to repeatedly justify medical frailty through burdensome documentation processes, adding uncompensated administrative workload; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services and state Medicaid agencies establish a standard with which to define "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies; this definition shall explicitly include, at a minimum, any individual currently undergoing diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a life-threatening or complex chronic medical condition, as well as conditions in which the disease or its treatment results in functional limitation or an ongoing need for medical care, while preserving the authority of states to expand these protections to additional populations (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal and state Medicaid guidance to provide automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients with complex medical conditions, utilizing evidence-based clinical data and claims-based algorithms to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. American Society of Clinical Oncology. 2026 ASCO Position Statement: Implications for Cancer Care in a New Medicaid Era. Published March 2, 2026. https://cdn.bfldr.com/KOIHB2Q3/as/hs3j3rxr3ccjt44cmvpq96/2026-ASCO-Medicaid-Position-Statement
2. Association for Clinical Oncology. Medicaid. Advocacy Agenda & Initiatives. April 2026. https://www.asco.org/get-involved/advocacy/advocacy-agenda-initiatives/medicaid
3. American Medical Association. Letter to Daniel Brillman, Director, Center for Medicaid & CHIP Services, Re: Implementation of Medicaid Community Engagement Requirements. March 9, 2026.
4. KFF. Tracking Implementation of the 2025 Reconciliation Law: Medicaid Work Requirements. Published March 6, 2026. https://www.kff.org/medicaid/medicaid-work-requirements-tracker-overview

RELEVANT AMA POLICY

H-290.963 Federal Medicaid Funding
Our AMA will advocate that any Medicaid community engagement or work requirements include clear and robust processes to appropriately exempt individuals who are medically frail or have serious or complex medical conditions. [CMS Rep. 05, I-17; Reaffirmed: CMS Rep. 05, A-22]

H-290.965 Affordable Care Act Medicaid Expansion
Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents. [CMS Rep. 2, A-14; Reaffirmed: CMS Rep. 05, A-22]

H-55.969 Cancer Survivorship Care Plans
Our AMA (1) recognizes that cancer survivorship care is a distinct and vital component of the cancer care continuum and (2) supports the development and use of survivorship care plans to improve the quality of care for cancer survivors. [Res. 518, A-11; Reaffirmed: CSAPH Rep. 01, A-21]

D-290.979 Affordable Care Act Medicaid Expansion
Our AMA will support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act and will advocate for the maintenance of the vital safety net provided by the Medicaid program. [CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 5, I-20]

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 244
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Eliminate Administrative Barriers to Appeal Wrongful Denials

Referred to: Reference Committee B

Whereas, health plans and insurance companies impose unreasonable burdens to appeal claim and services denials by requiring submission of redundant forms and fail to honor consent forms and authorizations signed by a patient; and

Whereas, for out-of-network providers in particular, many health plans demand that a separate "designation of authorized representative" form be filled out by a patient, long after the patient is gone, to appeal claim denials and when a patient switches a plan, a new form has to be filed even as patients expect, demand, and have previously authorized physicians to appeal on their behalf promptly and without imposing administrative burdens on patients; and

Whereas, health plans fail to honor previously signed generic "designation of authorized representative" forms; and

Whereas, the United States Department of Labor is authorized to regulate the claims procedure under Title 29 of the U.S. Code[1]; therefore be it

RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal plans without requiring plan-specific forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. 29 CFR § 2560.503-1 - Claims procedure. https://www.law.cornell.edu/cfr/text/29/2560.503-1. Accessed April 8, 2026.

RELEVANT AMA POLICY

Medicare Advantage Plans Double Standard H-330.863
Our AMA will seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor.
Citation: Res. 109, A-25

Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals D-120.959
Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals D-120.959
Citation: Res. 212, A-08; Reaffirmed: BOT Rep. 04, A-20

Insurance Coverage Appeals D-320.993
Our AMA will:
(1) continue to support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;
(2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;
(3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;
(4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;
(5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and
(6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations.
Citation: BOT Rep. 23, A-06; Modified: CMS Rep. 01, A-16; Reaffirmed: I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-26)

Introduced by: Private Practice Physicians Section

Subject: State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA

Referred to: Reference Committee (Assigned by HOD)

Whereas, AMA policy D-385.944, "ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers"[1] seeks to support states in implementation of state-based regulation of ERISA plans to the extent allowed by the U.S. Supreme Court decision in *Rutledge v. PCMA*; and

Whereas, the Employee Retirement Income Security Act (ERISA) does not address interest payments on overdue "clean" health insurance claims and many states such as New York have laws in place that require health plans to pay interest[2]; and

Whereas, ERISA does not address timeliness of response to prior authorization requirements, duty to obtain data that is available to health plans from sources other than physicians that health plans may need for prior authorization (test results, list of current medications); and

Whereas, ERISA does not address payments for services based on the coordination of benefits, requiring a health plan to pay at the in-network level of benefits for covered services when it is secondary to Medicare and the provider is a Medicare-participating provider, and secondary Medicare payments are not regulated under Medicare; and

Whereas, AMA policy D-320.978, "Fair Reimbursement for Administrative Burdens"[3] states that physicians should be fairly compensated for administrative work related to prior authorization, appeals of prior authorization denials, and appealing wrongful pre- and post-service denials for administrative work reflecting the actual time expended by physician practices and their billing vendors advocating on behalf of patients, complying with insurer requirements, and successfully appealing wrongful service denials; despite AMA policy, ERISA does not address prior authorization or compensation for the administrative work associated with prior authorizations or compensation for various administrative burdens associated with prior authorizations; and

Whereas, ERISA does not address parity for telehealth-assisted services, which may also be delivered using virtual reality in the future, nor does it refer to the site of service or technology used for care delivery, likewise, it does not address compensation for treatment of conditions that are already covered and the same medical services for the same conditions are delivered when appropriate via telehealth and in-person; and

Whereas, ERISA requires a plan administrator to make a claims decision "within a reasonable period of time, but not later than 30 days after receipt of the claim," but there is no regulation of the timeliness of the payment for the claim[4]; further, states like New York require[5] health plans to pay claims within 30 days "when the insurer's obligation to pay the claim is reasonably clear" and applying similar requirements to ERISA plans would significantly improve the sustainability and financial viability of physician practices; and

ERISA does not address payment recovery or recoupment by health plans and IRS regulations are separate from ERISA and allow recoupment from any third party (participant, another plan, etc.) or the plan must pay in for its own mistakes; therefore be it

RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices (Directive to Take Action); and be it further

RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians (Directive to Take Action); and be it further

RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including:

1. Interest payments on overdue "clean" health insurance claims not otherwise addressed by ERISA's statutory mandate;
2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources;
3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan;
4. Payment for the administrative burden of prior authorization and successful denial appeals;
5. Parity for telehealth-delivered services;
6. Timely payment of "clean claims" when the insurer's obligation to pay the claim is reasonably distinct from timely determination of claims;
7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies;
8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor.

(Directive to Take Action)

Fiscal Note: Major – $127,219. Legal analysis, creation of educational programming/modules.

Received: 4/20/26

REFERENCES

1. ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (D-385.944), American Medical Association.
2. Office of the General Counsel of the Department of Financial Services of New York State. (2001). Opinion re: health claims interest rate. https://www.dfs.ny.gov/insurance/ogco2001/rg110231.htm
3. Fair Reimbursement for Administrative Burdens (D-320.978). American Medical Association
4. Employee Benefits Security Administration. Benefits claims procedure regulation FAQs. US Department of Labor. Accessed March 13, 2025: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation
5. Department of Financial Services. (2021, March 15). Governor Cuomo announces new guidance for the Department of Financial Services for the fair and prompt payment of health insurance claims. State of New York. Accessed March 13, 2025: https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202103151
6. Opposition to Reduced Payment for the 25 Modifier (D-385.956). American Medical Association.

RELEVANT AMA POLICY

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944
Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.
Citation: Res. 224, I-23

Fair Reimbursement for Administrative Burdens D-320.978
1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22

Opposition to Reduced Payment for the 25 Modifier D-385.956
Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.
Citation: Res. 808, I-17; Reaffirmed: CMS Rep. 07, A-23

Uses and Abuses of CPT Modifier -25 D-70.971
1. Our American Medical Association Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.
2. The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.
3. Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.
4. Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.
5. Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.
6. Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.
7. Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.
8. Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

Citation: BOT Rep. 10, I-03; Reaffirmed: A-10; Reaffirmed: A-19; Reaffirmed: CMS Rep. 07, A-23

Remuneration for Physician Services H-385.951

1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed; A-11; Reaffirmed in lieu of: Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed; 811, I-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 30, A-24; Reaffirmed: BOT I-24; Reaffirmed: Res. 801, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Artificial Intelligence Scope of Practice

Referred to: Reference Committee B

Whereas, artificial/augmented intelligence (AI) can assist with the transformation of healthcare by enhancing diagnostic capabilities through tools like remote patient monitoring and automated administrative tasks; and

Whereas, AI can provide accessible health education to patient through online platforms and apps; and

Whereas, AI can assist primary care physicians providing rural care for data analysis, leveraging large datasets to provide care similar to that available in urban centers; and

Whereas, the "Healthy Technology Act of 2025" (H.R. 238) has been introduced in the United State House of Representatives to explore the possibility of allowing Food and Drug Administration-approved AI to prescribe drugs; and

Whereas, Doctronic, a Utah technology company in partnership with the Utah Office of Artificial intelligence Policy, gained authority under a pilot project for artificial intelligence to renew prescriptions independently[1]; and

Whereas, Cicero, a policy entity in Austin, Texas, has created model legislation for an autonomous artificial intelligence provider[2]; and

Whereas, the One Big Beautiful Bill that passed the U.S. House of Representatives approved a 10-year moratorium on state AI legislation that was not included in the version passed by the U.S. Senate[3]; and

Whereas, Executive Order 14179 restores government control over artificial intelligence and imposing limitations on states' rights to develop and implement laws relating to artificial intelligence[4]; therefore be it

RESOLVED, that our American Medical Association will develop model legislation declaring that artificial intelligence will not be used as a prescriptive or care management substitute for a physician (Directive to Take Action); and be it further

RESOLVED, that our AMA will develop model legislation prohibiting the Federation of State Medical Boards from enabling independent licensure be granted to artificial intelligence "providers." (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

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4. Executive Order 14365, FR Doc 2025-23092. (2025). https://www.whitehouse.gov/presidential-actions/2025/12/eliminating-state-law-obstruction-of-national-artificial-intelligence-policy. Accessed March 23, 2026.

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25.

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing

patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmed: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25.

Assessing the Intersection Between AI and Health Care H-480.931

Augmented Intelligence Development, Deployment, and Use in Health Care

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

additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.

iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.

vi. Description of how impacted populations were engaged during the AI lifecycle.

vii. Detailed information regarding data used to train the model:

1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:

1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:

1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

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

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
    f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

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

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

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

8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising

directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
    f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
    g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems

so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247
(A-26)

Introduced by: Texas

Subject: Comprehensive ERISA Reform

Referred to: Reference Committee B

Whereas, self-insured plans are regulated at the federal level by the Employee Retirement Income Security Act (ERISA) and are exempt from most state insurance laws, rules, and oversight; and

Whereas, according to a 2024 study by the Kaiser Family Foundation, approximately 63% of workers under the age of 65 are enrolled in self-insured health plans; and

Whereas, ERISA provides minimal federal regulatory protections for physicians and patients enrolled in self-insured plans from burdensome, inconsistent, or egregious payer policies; and

Whereas, while Texas enforced prompt pay regulations for fully insured (state regulated) health plans, there are few, if any, comparable federal prompt pay protections under ERISA for self-insured plans; and

Whereas, Texas law places limits on the timeframe during which insurers can request refunds or make payment recoupments under state-regulated plans, yet such consumer and provider protections are largely absent under ERISA for self-insured plans; and

Whereas, Texas imposes standards on prepayment claims audits for fully insured plans, but no equivalent federal standards exist under ERISA for self-insured plans; and

Whereas, Texas has implemented regulations regarding prior authorization processes and timelines for state-regulated plans, but these protections do not apply to self-insured plans governed by ERISA; and

Whereas, Title 29, Chapter 18, subchapter I, Part 5 of ERISA (29 US Code § 1144) broadly preempts “any and all State laws” insofar as they “relate to” employee benefit plans, and repeated efforts to eliminate or narrow this preemption have been unsuccessful; and

Whereas, among all states, Texas has implemented the most comprehensive laws addressing prompt payment requirements, refund and recoupment timeframes, prepayment claims audit standards, and prior authorization processes; therefore be it

RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after the Texas Prompt Pay laws and rules, requiring a report back at the following annual meeting. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

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3. Texas Administrative Code, Title 28, Part 1, Chapter 11 – Health Maintenance Organizations, Subchapter J – Physician and Provider Contracts and Arrangements §11.900 – 11.904. Appianportalsgov.com. Published 2026. Accessed April 20, 2026. https://texas40 sos.appianportalsgov.com/rules-and41 meetings?chapter=11&interface=VIEW_TAC&part=1&subchapter=J&title=28

RELEVANT AMA POLICY

Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926
Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959
Insurance Reimbursements D-190.977
Required Clinical Qualifications on Determining Medical Diagnoses and Medical Necessity D-320.975
Additional Prompt Payment Advocacy H-385-927
Insurance Companies Use of Contractors to Recover Payments D-385.965
Payment for Pre-Certified/Preauthorized Procedures H-385.900
Medical Office Screens H-335.981
Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims H-385.967
AMA Policy on ERISA H-285.915
ERISA Preemption and State Prompt Pay Laws D-385.984
ERISA and Managed Care Oversight D-383.984
Time Sensitive Credentialing of New Providers with an Insurance Carrier D-285.956
ERISA and Health Plan Related Legislation D-190.996
ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944

Reference Committee C

Report(s) of the Council on Medical Education

01 Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
02 Examining ABMS Processes for New Boards
03 Support for the Establishment of Indigenous-Led Medical Schools in the United States
04 Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Resolutions

301 Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies
302 Excessive Cost of Multi-State DEA Licensure
303 Allowing Options for Certification Maintenance
304 Increasing the Use of Retired Physicians in Teaching Students and Residents
305 Leadership by Physicians for Physicians in Graduate Medical Education (GME)
306 Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
307 Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
308 Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
309 Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
310 Increasing Capacity and Access to Maternal Health Services in Rural Areas
311 Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall
312 Advocating for Equitable Application Review in a Single Match System
313 Evaluation of Situational Judgement Tests in Medical School Admissions
314 Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
315 Expanding the Native Hawaiian Health Scholarship Program Eligibility
316 Addressing Transitions Within GME Regarding Orientation Standards
317 Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-26

Subject:	Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
Presented by:	Kelly Caverzagie, MD, MPH, Chair
Referred to:	Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

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 ten 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 ten-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.

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RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Fiscal Note: Minimal

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-275.953	Protection of Physicians' Personal Information	Our AMA will work with the Federation of State Medical Boards to standardize the publicly available data on the State Medical Boards' websites to protect the personal data of physicians to decrease the risk of identity theft. Policy Timeline: Res. 602, A-16	Rescind – accomplished. Update provided to HOD after A-16 stated that a letter was sent to the Federation of State Medical Boards (FSMB) to notify them of the House action. In part, the letter addressed the disclosure of multiple data elements about physicians on state medical board websites. The letter asked that state medical boards be encouraged to limit the personal information displayed on their websites to the minimum necessary to reduce the possibility of identity theft among physicians. The House action also was transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and those leading other interested groups via the AMA MedEd Update newsletter. There is currently no national standard for displaying physician information on websites. While states vary in their approaches given different priorities and state laws, there is convergence on not posting the most sensitive identifiers (e.g., full Social Security number, full date of birth, bank numbers, or tax numbers, etc.). These identifiers may be collected and stored in licensing records. FSMB does not collect comprehensive state-based data on this issue.
D-295.949	Criminal Background Checks for Medical Students	Our AMA will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of guidelines for appropriate action related to individuals whose background checks raise concerns; (2) work to ensure that systems for criminal background checks for accepted applicants and medical students are standardized within and across institutions, as well as equitable, cost-	Retain clause 1 and amend by addition and deletion to read: Our AMA ~~will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for~~ encourages (1) criminal background checks for applicants accepted to medical school and enrolled medical students,~~ including the creation of~~ and (2) dissemination of guidelines for appropriate action related to individuals whose background checks raise concerns. Rescind clauses 2 and 3 – accomplished. Update provided to HOD after A-06 stated that the House action was transmitted to medical school deans, residency program

		effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and (3) continue to monitor the requirement for criminal background checks for accepted applicants and medical students by medical schools, hospitals/health systems, and state laws. Policy Timeline: CME Rep. 9, A-06; Reaffirmed: CME Rep. 01, A-16	director, and directors of medical education at U.S. teaching hospitals via the AMA Medical Education Bulletin; and that the Council on Medical Education would work with other AMA Councils and Sections as well as the Association of American Medical Colleges (AAMC) to develop guidelines. Related information provided on AAMC and American Association of Colleges of Osteopathic Medicine websites.
D-295.313	Telemedicine in Medical Education	1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. Policy Timeline: CME Rep. 06, A-16	Retain – still relevant; amend clauses 1 and 2 by addition and deletion to read: 1. Our AMA encourages appropriate ~~stakeholders~~ interested parties to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate ~~stakeholders~~ interested parties to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. Update provided to HOD after A-16 stated that the Association of American Medical Colleges, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine, Liaison Committee on Medical Education. and Accreditation Council for Graduate Medical Education were notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter.
D-300.977	ACCME Proposed Changes in "Accreditation with Commendation" Continuing Medical Education Criteria Assessment Methodology	Our AMA will continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME) "Accreditation with commendation" criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented. Policy Timeline: Res. 313, A-16	Rescind – accomplished. Currently, a member of the AMA Council on Medical Education serves on the ACCME Board of Directors and provides updates to the Council. Update provided to HOD after A-16 stated that the Council on Medical Education prepared informational report CME 8-A-17 on this subject.

			ACCME's Accreditation with Commendation criteria were updated in 2016 and have been in effect for decisions made after November 2019. New Standards for Integrity and Independence in Accredited Continuing Education went into effect January 2022.
D-310.951	Mitigating Abusive Pre-Certification / Pre-Authorization Practices	Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage residency programs to offer administrative resources to housestaff for practice-based support, including but not limited to pre-certification and pre-authorization of medications and services. Policy Timeline: Res. 716, A-16	Rescind – accomplished. Update provided to HOD after A-16 stated that the Accreditation Council for Graduate Medical Education was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter.
H-275.936	Mechanisms to Measure Physician Competency	Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. Policy Timeline: Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12; Modified: Res. 309, I-16	Rescind – addressed by H-275.916, H-295.862, H-275.924, D-275.954. Clause 3 is outdated. Update provided to HOD after A-16 stated that the American Board of Medical Specialties (ABMS) was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter. The Council on Medical Education continues to engage with the ABMS on ways in which the continuing board certification (formerly maintenance of certification) process can be made more meaningful, relevant, and reflective of the ways that physicians actually practice.
H-275.979	Medicare Reporting of Adverse Incidents in Hospitals to State Agencies	The AMA opposes the sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies until hospital quality assurance committees have been notified and given a reasonable time to respond.	Retain – still relevant.

		Policy Timeline: Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
H-275.980	Funding of State Medical Boards	(1) The AMA urges state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its behalf, be specifically designated for use of the board(s) in fulfilling its duties under the state's medical practice act. (2) When such funds are inadequate to support such activities, state general funds should be used to support the board's effective fulfillment of its duties mandated by the state's medical practice act. Policy Timeline: Sub. Res. 23, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-275.997	Licensure by Specialty	Experience with licensure by specialty is too limited to determine what the long-range effects will be in the provision of timely, safe and comprehensive medical care. However, the AMA does not consider licensure by specialty to be desirable even in unusual cases. Policy Timeline: CME Rep. F, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 05, I-16	Rescind – addressed by H-275.978 clauses 2 and 16.
H-280.946	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	Our AMA urges long-term care facilities and other appropriate organizations to: (1) adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and (2) provide staff with in-service training to develop a framework to address intimacy in their patient population. Policy Timeline: Res. 403, A-16	Retain – still relevant. Notice provided to HOD after A-16 stated that the AMA Policy Database was updated.
H-295.912	Education of Medical Students and Residents about Domestic	Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical	Retain – still relevant.

	Violence Screening	education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. Policy Timeline: Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
H-295.915	Residency Program Responsibility for Resident Education	Our American Medical Association affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession. Policy Timeline: Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Rescind – addressed by policies H-275.916 and Opinion 8.13.
H-295.969	Nondiscrimination Toward Residency Applicants	Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation." Policy Timeline: Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07; Reaffirmed: CCB/CLRPD Rep. 1, A-14; Modified: CME Rep. 01, A-16	Retain; amend by addition and deletion to read: ~~Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."~~ Our American Medical Association encourages that Accreditation Council for Graduate Medical Education-accredited programs should not discriminate on the basis of an individual's sex, age, race, creed, national origin, gender identity, or sexual orientation. Discrimination is addressed by the ACGME in the 2025 Institutional Requirements, specifically: ● (3.2.f.4) addresses all discrimination, while not articulating the types. ● (4.2) addresses recruitment, selection, eligibility, and appointment ● (4.9.e) directs institutional policies prohibiting discrimination in employment and in the learning and working environment.
H-295.981	Geriatric Medicine	1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine	Retain – still relevant.

		into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs. 2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties. Policy Timeline: Res. 137, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: CSA Rep. 5, A-02; Appended: Res. 301, A-10; Reaffirmed: BOT Rep. 05, I-16	
H-300.951	Credit for Reading Medical Journals	The AMA continues to support appropriate credit for medical journal study and make every effort to simplify the process by which this is accomplished. Policy Timeline: Res. 315, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Rescind – accomplished. AMA Physician's Recognition Award and credit system booklet describes "journal-based CME" on page 4.
H-300.952	Dissemination of Information Regarding CME Activities	The AMA will continue to support the current system of Continuing Medical Education accreditation in which the Accreditation Council for Continuing Medical Education accredits sponsors whose mission and intended audience are on a regional or national level and state medical societies accredit sponsors whose mission and intended audience are physicians within state and contiguous states, following the guidelines enunciated by the ACCME.	Retain – still relevant.

		Policy Timeline: CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
H-300.955	Restructuring of Continuing Medical Education Credits	The AMA encourages state licensing boards with CME reporting requirements to allow *AMA PRA Category 1 Credit*" and *AMA PRA Category 2 Credit*" toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician's Recognition Award as evidence of completion of these requirements. Policy Timeline: CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-310.906	Improving Residency Training in the Treatment of Opioid Dependence	Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders. Policy Timeline: Res. 301, I-16	Retain – still relevant. Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.
H-310.982	Reevaluation of Residency Selection Process	Our American Medical Association supports continued cooperation with the Association of American Medical Colleges in the evaluation of the residency selection process, with emphasis on the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum. Policy Timeline: Sub. Res. 112, I-86; Amended by Sunset Report, I-96; Modified and Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-310.983	Residency Positions for Sale	Our American Medical Association reaffirms its position that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process.	Retain – still relevant. Append to H-305.925; amend by addition and deletion to read: 27. ~~Our American Medical Association reaffirms its position~~ Upholds that selection of residents should be based on the academic and personal qualifications of applicants and

		Policy Timeline: CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	that monetary considerations should never compromise the selection process."
H-345.970	Improving Mental Health Services for Undergraduate and Graduate Students	Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner. Policy Timeline: Res. 904, I-16	Retain – still relevant. Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.
H-345.973	Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians	Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. Policy Timeline: Res. 915, I-15; Revised: CME Rep. 01, I-16	Retain – still relevant. Notice provided to HOD after I-15 stated that the AMA Policy Database was updated.
H-405.962	The Practice of Public Health by Physicians	Our AMA: (1) recognizes the practice of public health by physicians as the practice of medicine; (2) opposes specialty-specific license restrictions for American Board of Medical Specialties (ABMS)-recognized specialties; and (3) encourages the ABMS and the Federation of State Medical Boards to adopt similar policies recognizing the practice of public health by physicians as a legitimate practice of medicine and opposing specialty-specific license restrictions for ABMS-recognized specialties. Policy Timeline: Res. 815, I-06; Reaffirmed: CME Rep. 01, A-16	Retain clause 1 – still relevant. Rescind clauses 2 and 3 – accomplished. Public health is recognized by the ABMS: Specialties - The American Board of Preventive Medicine. All certifications offered by ABMS Member Boards are endorsed by the ABMS and require approval when they offer a new certification or focused practice designation. No state requires any certification (ABMS or otherwise) to obtain a license to practice medicine. ABMS and FSMB have long held that ABMS certification is voluntary and should not be tied to requirements to obtain a

			state medical license, which aligns with other AMA policy.
H-405.966	Resident Physician Licenses	Our American Medical Association supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state. Policy Timeline: Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.

COUNCIL ON MEDICAL EDUCATION REPORT 2-A-26
Examining ABMS Processes for New Boards

EXECUTIVE SUMMARY

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates Policy D-275.943, "Examining ABMS Processed for New Boards," was adopted. The policy asks that the AMA "study and define principles for board certifying bodies including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026."

This report provides a brief history of specialty board formation and American Board of Medical Specialties (ABMS) approval as well as an overview of past and current ABMS requirements and criteria. It discusses input from the HOD and offers principles for board certifying bodies. Finally, the report lays out resources and related AMA policy and concludes with recommendations to the HOD.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-26

Subject: Examining ABMS Processes for New Boards

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 301 was co-sponsored by the American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography & Interventions, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance. Their original resolution raised concern for established criteria of oversight bodies and American Board of Medical Specialties (ABMS) processes for new boards. It specifically referenced the application of a new American Board of Cardiovascular Medicine (ABCVM). Testimony addressed support for the belief that board certification is paramount in professional self-governance and that AMA should not interfere with the American Board of Medical Specialties (ABMS) process. Alternate Resolution 301 was adopted as amended in lieu of original Resolution 301 and is now AMA Policy D-275.943, "Examining ABMS Processes for New Boards," which asks the following:

> Our AMA will study and define principles for board certifying bodies including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026.

This report is written in response to its directive.

BACKGROUND

At the 2023 Interim Meeting, the AMA HOD adopted CME Report 4, "Recognizing Specialty Certifications for Physicians." It provided a detailed history of standardized certification, ABMS, Accreditation Council for Graduate Medical Education (ACGME) core competencies, governance of ABMS member boards, and ABMS board eligibility. The report also explained board eligibility for the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS), and other entities such as the American Association of Neuromuscular & Electrodiagnostic Medicine, American Board of Cosmetic Surgery, American Board of Facial Plastic and Reconstructive Surgery, American Board of Oral & Maxillofacial Surgery, American Board of Physician Specialties, National Board of Physicians and Surgeons, and United Council for Neurologic Subspecialties. Further, it addressed the AMA's Truth in Advertising Campaign. A review of CME 4-I-23 provides historical information and useful context for this report.

History of specialty board formation and ABMS approval

The need for board certification can be traced back to the late 19th century when it was recognized that medical education and training varied widely. Given the lack of universal curricula and

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evaluation methods, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. The American Board of Ophthalmology was established in 1917 as the first board allowing ophthalmologists to distinguish themselves from other physicians. As other boards began to form, the AMA established the Advisory Board for Medical Specialties in 1933 to bring order to this growing arena and address conflicts.[1] This board established the first *Essentials for Approval of Examining Boards in Medical Specialties*, which was approved by the HOD in June 1934. The Essentials described "the standards and procedures by which applications for approval of new medical specialty boards are evaluated."[2] In 1942, the AMA Council on Medical Education and Advisory Board established the Liaison Committee for Specialty Boards (LCSB) to receive applications for approval as a medical specialty certifying board and evaluate applications. The Advisory Board was renamed the American Board of Medical Specialties (ABMS) in 1970.[3] As of June 2025, ABMS represents 24 certifying boards and just over one million active board-certified physicians.[4] Over time, other entities were established to provide board certification. For example, the AOA formed the Advisory Board for Osteopathic Specialists in 1939 to oversee the certification of osteopathic physicians; it eventually became the AOA Bureau of Osteopathic Specialists (AOA-BOS).[5]

The HOD approved the twelfth and final revision to the *Essentials*, and they became effective in November 2005. These *Essentials* were implemented until 2023 when ABMS updated their policy to change the process for approval of medical specialty boards. Effective October 27, 2023, the ABMS Board of Directors adopted new Policy 1.8 on Admission of New Medical Specialty Boards to Membership in ABMS[6], thereby establishing a new process for board approval and ending the LCSB. Similar to the *Essentials,* ABMS Policy 1.8 lays out eight sections that describe the plans and steps necessary for the creation of a new specialty board.

DISCUSSION

Current requirements and criteria per ABMS Policy 1.8

The current necessary requirements to be recognized as an independent board are described in "Section III. Required Content for Applications." This section states, "In order to be recommended for approval by the ABMS Advisory Body on Specialty Board Development ('Advisory Body' [see Section IV]), a new applicant specialty board must demonstrate that all of the following requirements have been satisfied.

1. The applicant board must demonstrate that it is primarily composed of Diplomates who hold a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or foreign equivalent (e.g., Bachelor of Medicine, Bachelor of Surgery [MBBS]) degrees. The ABMS Board of Directors will determine whether this criterion has been satisfied in its sole and absolute discretion based on the unique circumstances of each applicant board.
2. The applicant board must define its objectives and function, including a scientific rationale demonstrating a substantial advancement in medicine or technology, evidence of a distinct and well-defined field of medical practice, and/or confirmation of an interdisciplinary practice field sufficiently distinct from existing fields of practice. The applicant board must present data on the field's core content/competencies and scope of practice based on a validated blueprint of the professional area, including present and projected future public needs and expected growth.
3. The applicant board must present a rationale for how this field of practice serves the patient/public interest, as well as supports candidates'/Diplomates' needs.
4. The applicant board must demonstrate how its training and evaluation methods satisfy ABMS' standards.

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5. The applicant board must describe the training needed to meet requirements for certification and delineate how this training is sufficiently distinct from the training required for certification by existing ABMS medical specialty boards.
6. The applicant board must define standards for the requisite knowledge and skills in the field of practice. They must demonstrate that candidates for initial certification acquire and maintain these standards. A specific plan for development and validation of the requirements for initial and continuing certification must be presented, along with an outline of and rationale for the qualifications to be required of candidates for certification. The applicant board also must provide a detailed explanation of how the program will adhere to ABMS' initial, continuing, and organizational standards and provide a detailed plan for program review and evaluation.
7. Except as provided in this section, the applicant board must require all new Diplomates to successfully complete an ACGME-accredited residency or training program prior to becoming certified. If the applicant board is in the process of obtaining ACGME accreditation for the GME training program(s) for the field of practice at the time of application for admission to the ABMS (and if all other conditions are satisfied), the ABMS Board of Directors may conditionally approve the applicant board contingent upon ACGME accreditation of the program(s). Applicant boards may not issue new certificates under the ABMS imprimatur or use the ABMS seal until final approval as a medical specialty board has been granted by the ABMS.
8. A plan must be presented to accommodate the certification of individuals who complete their GME prior to the establishment of ACGME-accredited or other accredited programs in the specialty. A description of the practice requirements for Diplomates practicing in the field of practice without ACGME-accredited training must be provided. The description should include a summary of the qualifications, the examination(s) required, and the number of physicians or medical specialists to be certified in this manner. Applicant boards with existing certified diplomates at the time of application to membership in the ABMS must present a plan to accommodate the ABMS certification of individuals if such ABMS certification for existing diplomates is desired by the applicant board.
9. The applicant board must demonstrate broad support from the relevant field of medical practice and broad professional support. The applicant board must provide the communications used to notify the field of medical practice of the proposed application.
10. The applicant board must provide the total number, along with the complete list of institutions providing residency or other acceptable training programs in the field of practice; the total number of residency positions available; and the number of residency programs planned for creation within the next five years. This data should demonstrate the growth and sustainability of these training programs. The applicant board further must provide the following:
11. The official name of the proposed board, including the names and professional qualifications of its officials and the organization that each official represents (if applicable).
12. An operational plan, including sufficient detail for evaluation of the following areas:
    - MISSION AND OPERATIONS: The applicant board must have a mission that aligns with the mission of ABMS and articulates the purpose of board certification in the proposed field of medical practice. The applicant board will provide copies of existing policies and procedures that promote professionalism and excellence in operations and that strive to meet the needs of the public and the profession. The applicant board is expected to conduct periodic reviews of its operations as supported by principles of good governance.
    - GOVERNANCE STRUCTURE: The applicant board must demonstrate that its Board of Trustees/Directors follows best practices for governance and is able to

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address the needs and concerns of its stakeholders. Board members should have sufficient professional expertise for effective board operation and management. The applicant board must specifically articulate how the perspectives of active clinician Diplomates, stakeholders in the field of medical practice, patients, and the public inform board governance, and must explain the presence or absence of any structural or process components related to equity.

- BUSINESS PLAN: The financial support for a valid, objective program of candidate and Diplomate assessment must be presented, and the applicant board must attest that adequate resources and revenue are available to support and sustain the applicant board. The data should include the approximate number of physicians or medical specialists currently engaged in the practice of the field of medical practice, as well as projected numbers of examinees for initial and continuing certification and projected certification fees. The applicant board must reflect appropriate, transparent financial stewardship in a manner befitting its non-profit status,

13. A copy of the Constitution (if applicable) and Bylaws;
14. A copy of the Articles of Incorporation;
15. A copy of the application form for candidates for initial and continuing certification; and
16. A non-refundable application fee."[6]

Notable differences between the former *Essentials* and new Policy 1.8 include: removal of language regarding the LCSB, reframing oversight and procedure for the recommendation of approval of new specialty boards as solely under ABMS purview, updating of terms (e.g., MOC now referred to as continuing board certification), change from "appeal" to "reapplication," and new reference to "conjoint" boards. Regarding the role of the AMA in this new process, Section IV of Policy 1.8 explains that the sitting Chair of the AMA Council on Medical Education or their designee is a participant in the Advisory Body without vote. Further, ABMS will inform the AMA of the general activities of the Advisory Body once convened, including notification of scheduled meetings, notices of public comment periods, and general timelines related to the work of the Advisory Body.

Input from the HOD

Comments are regularly submitted to the HOD via the "Forthcoming and Pending Reports for the House of Delegates" document to inform the drafting of forthcoming and pending reports. Three comments were submitted regarding Resolution 301/Policy D-275.943. They were reviewed and considered during the development of this report. One comment suggested that the AMA more formally acknowledge the optional drafting note stated in the AMA Truth in Advertising (TIA) campaign, as seen on page twelve of the TIA Campaign booklet. However, there remains an issue of consensus regarding the definition of board certification that will need to be addressed by the HOD.

Principles for board certifying bodies

Policy D-275.943 asks the AMA to develop principles for board certifying bodies with the goal of providing a clear foundation that guides optimal performance of such bodies and further strengthens a commitment to evidence-based lifelong learning. Principles for board certifying bodies should be broad and comprehensive assumptions in alignment with AMA policy. In the development of such principles, careful consideration was given to the policies and protocols of the ABMS and AOA-BOS, the interest expressed in the underlying resolution (to include addressing education and training requirements, initial and ongoing assessment of physician competence, patient safety, and professional self-regulation), testimony from the HOD, and other input from

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interested parties. Principles are intended to be guiding concepts and not replace or supersede established policies and protocols. The Council on Medical Education offers the following principles.

Physician board certifying bodies should:

1. Serve the public interest by supporting high-quality evidence-based care, patient safety, professionalism, and ethical conduct of individual physicians.

2. Maintain independent governance, ensure equitable and transparent processes, engage relevant parties, and uphold fair pathways for transition or reapplication when establishing criteria for certification.

3. Align certification with recognized education and training, clearly define competencies, and use objective, standards-based assessments that reflect clinical practice.

4. Incorporate ongoing evaluation and improvement, supported by effective use of technology to enhance accessibility and efficiency.

5. Ensure representative physician leadership informed by diverse practice settings and provide opportunities for diplomates to participate in governance. *

* Principles created with author oversight by Microsoft Copilot, March 4, 2026.

Update on American Board of Cardiovascular Medicine (ABCVM)

On January 23, 2026, ABCVM issued an update on their status, noting that their "Board of Directors continues to evaluate partnerships with organizations, such as the National Board of Physician and Surgeons (NBPAS), the American Board of Physician Specialties (ABPS), and the American Osteopathic Association (AOA), to accelerate innovation. However, differences in scale, resources, recognition and philosophy limited these options."[7] NBPAS published commentary on this decision, stating that "differences in philosophy ultimately precluded a partnership at this time.[8] In addition, it noted, "From its founding, NBPAS has maintained a clear and consistent mission: to provide a credible, rigorous pathway and platform for lifelong learning without imposing unproven requirements such as point-in-time examinations or longitudinal testing models." ABPS and AOA had not published commentary at the time of the preparation of this report.

Resources

The ABMS website provides general information as well as the following resources:

- Standards for Initial Certification – Presents the standards and annotations for Initial Certification, requirements for each ABMS Member Board's program, and potential pathways to meet the requirements. Of note, ABMS announced on February 27, 2026, a call for comment on Draft Revised Standards for Initial Certification, due April 27. The Council on Medical Education intends to provide comments which will be after the deadline for submitting this report.
- The Recommendations of the Vision Initiative Commission – 2019 report by an independent commission containing fourteen recommendations that address current concerns and outline a path forward for ABMS' continuing certification programs.

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- Standards for Continuing Certification – Effective January 2024, provides a comprehensive framework for Member Boards to design certification programs that meaningfully engage diplomates in activities relevant to their practice.
- ABMS Guide to Medical Specialties – Provides descriptions and contact information for the ABMS member board specialties and subspecialties.
- ABMS Board Certification Report – Released annually, it contains data on the specialty and subspecialty certificates approved by ABMS, the number of new specialty and subspecialty certificates issued in the last 10 years, and the distribution of board-certified diplomates by ABMS Member Board, specialty, and state.

Other board certification entities provide their own information. For example, the AOA website offers the "Handbook of the Bureau of Osteopathic Specialist," which includes AOA-BOS policies and new board processes.

RELEVANT AMA POLICY

AMA Policy H-275.926 "Medical Specialty Board Certification Standards" addresses board certified physicians, ABMS member boards, and ABMS/AOA-BOS board certification processes. Of note, the third clause states, "It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both

a. a process for defining specialty-specific standards for knowledge and skills and
b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination."

Given the *Essentials* are defunct, this reference should be removed from clause (3b) of the policy.

AMA Policy D-275.943 "Examining ABMS Processes for New Boards," is the policy resulting from adoption of Resolution 301 that calls for this report. This report fulfills that directive.

CONCLUSION

Board certification provides an ongoing independent evaluation of individual physicians to assure that the specialty physician workforce is clinically competent, skilled, participates in lifelong learning, and meets the standards of practice established by their peers. Further, there is public interest in seeking out board-certified physicians and specialists. The public seeks to trust their physicians with the significant responsibility of care and decision making when it comes to both personal and population health. Such trust exemplifies great public value. Contributing factors to the building of such trust include demonstrated quality care and patient safety as well as expertise and ongoing professional development – all of which are represented through board certification. Board certification also provides a process to ensure new boards meet the same foundational principles that guide certification itself including competency standards, training requirements, public accountability, and the ability to perform valid, independent assessments. Thorough, high-quality requirements and protocols for new boards are imperative. AMA's continued collaboration with its HOD, ABMS and its member boards, AOA-BOS, and other board certifying entities will ensure ongoing prioritization and review of board approval processes.

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RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 301-A-25, and the remainder of the report be filed:

1. Policy H-275.926,"Medical Specialty Board Certification Standards," item 3b, be amended by deletion to read as follows:

   3b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. ~~In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.~~ (Modify Current HOD Policy)

2. Our AMA supports the following principles to inform the development of new board certifying bodies:

   Principles for New Board Certifying Bodies

   1. Serve the public interest by supporting high-quality evidence-based care, patient safety, professionalism, and ethical conduct of individual physicians.
   2. Maintain independent governance, ensure impartial and transparent processes, engage relevant parties, and uphold fair pathways for transition or reapplication when establishing criteria for certification.
   3. Align certification with recognized education and training, clearly define competencies, and use objective, standards-based assessments that reflect clinical practice.
   4. Incorporate ongoing evaluation and improvement, supported by effective use of technology to enhance accessibility and efficiency.
   5. Ensure representative physician leadership informed by diverse practice settings and provide opportunities for diplomates to participate in governance.

   (New HOD Policy)

3. Policy D-275.943, "Examining ABMS Processes for New Boards," be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Fiscal note: Minimal

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RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
    a. a process for defining specialty-specific standards for knowledge and skills and
    b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees, and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Examining ABMS Processes for New Boards D-275.943

Our AMA will study and define principles for board certifying bodies including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026.

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COUNCIL ON MEDICAL EDUCATION REPORT 3 – A-26
Support for the Establishment of Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolves 2 and 4 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, were referred for study on the following topics:

> RESOLVED (2), that our AMA work collaboratively with Tribal Nations, Indigenous-led organizations, academic institutions, and relevant governing bodies to explore the feasibility, infrastructure, and resource needs for such an institution (Directive to Take Action); and be it further
>
> RESOLVED (4), that our AMA advocate for funding and resource development, including through partnerships with academic, philanthropic, health system, and governmental stakeholders, to support sustainable development and operation of an Indigenous-led medical school. (Directive to Take Action)

This report reviews the history and context of physician workforce shortages in Indigenous communities, including the difficulties present early in the educational and other pathways leading up to medical school and the current absence of any Indigenous-led medical school. The report then summarizes the basic process to create a medical school and discusses unique challenges related to implementing this process on tribal land. Finally, the report explores activity in the wider medical education community related to tribally affiliated medical schools, a selection of other relevant Indigenous-focused programs, and AMA's current work related to Indigenous workforce and possible Indigenous medical schools.

The report recommends additional AMA policy in convening, collaboration, feasibility assessment, and advocacy spaces related to Indigenous medical schools as well as pathway and mentorship programs prior to undergraduate medical education.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-26

Subject:	Support for the Establishment of Indigenous-Led Medical Schools in the United States
Presented by:	Kelly Caverzagie, MD, MPH, Chair
Referred to:	Reference Committee C

Resolution 303-A-25, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," was introduced by the Underrepresented in Medicine Advocacy Section (formerly the Minority Affairs Section), with resolves 2, 3, and 4 being referred. Resolve 3 will be studied in a separate report while the study of resolves 2 and 4 are the focus of this report. These resolves asked the following:

> RESOLVED (2), that our AMA work collaboratively with Tribal Nations, Indigenous-led organizations, academic institutions, and relevant governing bodies to explore the feasibility, infrastructure, and resource needs for such an institution (Directive to Take Action); and be it further
>
> RESOLVED (4), that our AMA advocate for funding and resource development, including through partnerships with academic, philanthropic, health system, and governmental stakeholders, to support sustainable development and operation of an Indigenous-led medical school. (Directive to Take Action)

"Such an institution" in resolve 2 refers to the original resolve 1 in the resolution, which became AMA Policy H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," and reads: "Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities."

BACKGROUND

Workforce Shortages

Tribal health care is in crisis, with disproportionately poor health outcomes for Indigenous people in the United States. One major basis of this crisis is a severe workforce shortage of Indigenous physicians who are more likely than their peers to serve Indigenous populations.[1,2] However, as discussed in Council on Medical Education Report 8-A-25, Disaggregation of Demographic Data for Indigenous Individuals: "AI/AN people experience significant challenges based on wider systemic oppression and difficulty in accessing education in general and, therefore, also are underrepresented in the number achieving high school and college degrees as well as in medical degrees.[3] According to the AAMC, in 2023, there were only 90 total AI/AN self-reported applicants to U.S. MD-granting medical schools, and 57 Native Hawaiian or Other Pacific Islander (though some Indigenous applicants may have been aggregated under other ethnic categories, such

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as multiracial.)"[4] By contrast, in 2023, there were 3.3 million people in the country who identified solely as American Indian/Alaska Native (AI/AN), with 581,100 more identifying as Native Hawaiian/Pacific Islander.[5] This is about 1.5 percent of the U.S. population, but AI/AN individuals account for only 0.28 percent of medical school applicants, with even fewer being accepted and graduating.[6] Among active physicians, in 2018 there were 3,511 total physicians identifying as American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander, in contrast to Indigenous patient populations in the multiple millions.[7]

Challenges related to AI/AN health outcomes, such as those connected to the Indian Health Service, also include inadequate funding, challenges associated with transitioning services from federal to Tribal control through contracting and compacting, evolving federal and state programs, the need for culturally sensitive services, and the promise and challenges of health technology. However, limited human resources are considered one of the top challenges.[8]

Given significant underrepresentation of AI/AN learners and physicians, it is critical to work directly with tribes on the creation of scholarships and programs to support the preparation of AI/AN individuals for medical school.[3] To support AI/AN access to medicine as a career, there are also significant needs that start as early as birth, pre-K, and K-16.[9,10,11] AMA currently has policy related to the importance of early childhood resources (Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917), as well as pre-K-16 pathway pilot programs (AMA Support of U.S. Pathway Programs D-200.970), and is engaged in grant work in this area, which includes but is not specifically for Indigenous populations.

Tribal and Indigenous Sovereignty

The multiplicity of Indigenous communities have varying priorities, including 574 American Indian and Alaska Native tribes and villages formally recognized by the U.S. federal government. Each of these entities has "a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States."[12] Solutions to severe Indigenous health disparities, such as an Indigenous medical school, may potentially involve direct ties to one or more tribal nations and must be driven by and for the unique needs and goals of those nations or communities.

Medical School Creation

A scoping review by Kirubakaran et al., published in 2024 in *Advances in Health Science Education*, reviewed the existing literature on the process for establishing new medical schools, noting that doing so is "a complex undertaking with high financial and political stakes." Though "the literature on new medical school establishment is empirically and theoretically under-developed, it is still useful and reveals a number of important considerations that could assist founding leaders and teams to maximize the outcomes and impact of their establishment efforts."[13] Generally speaking, plans for a new medical school must be both descriptive and substantive—a vision for what the values and purpose of a new medical school will be, in addition to specific plans related to both the creation and sustainability of the school.

The Liaison Committee on Medical Education (LCME) accredits allopathic medical schools in the United States. The LCME accreditation standards are included in the document "Functions and

Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree," available on the LCME website.[14] A developing medical school must demonstrate its potential to meet the requirements in accreditation standards by providing specific information in the Data Collection Instrument for Preliminary Accreditation Surveys.[14] The American Osteopathic Association, specifically the Commission on Osteopathic College Accreditation (COCA), accredits osteopathic medical schools in the United States and provides accreditation guidelines and policies on their website.[15]

While the administrative processes, resources, and other requirements may be similar to any other medical school in regard to creating a school and seeking allopathic or osteopathic accreditation, a tribal medical school may potentially have differences due to a tribe's status as a sovereign nation. No literature currently exists in this area, given that no tribal medical schools currently exist.

The LCME accredits educational programs that lead to the MD degree; it does not accredit institutions. A medical school or its sponsoring institution, such as a university, must hold institutional accreditation from an accrediting body recognized by the U.S. Department of Education for Title IV purposes.[16] This institutional accreditation is what allows students to access federal financial aid, such as low-interest student loans under Title IV of the Higher Education Act. In contrast, the COCA accredits DO-granting colleges of osteopathic medicine and is recognized by the U.S. Department of Education as an institutional accreditor, meaning COCA accreditation can satisfy Title IV institutional eligibility requirements for osteopathic medical schools.

Resource Development to Open and Sustain a Medical School

According to LCME staff, funding for a prospective medical school may come from a variety of sources and specifically requires a feasible plan and evidence for financial sustainability. The resources a school has access to prior to opening may differ from those in place later but must be sustainable for a period of time: often a clear, specific, and realistic budget for the next six years. A new school needs to consider the revenue sources available at the beginning and how these will change but remain sufficient over time.

Characteristics of Tribally-Owned Higher Education Institutions

According to the American Indian Higher Education Consortium (AIHEC), "Tribal Colleges and Universities (TCUs) are chartered by their respective Tribal governments, including the ten Tribes within the largest reservations in the United States. The 35 accredited TCUs operate more than 90 campuses and sites in 15 states—covering most of Indian Country—and serve students from more than 250 federally recognized Indian Tribes. TCUs vary in enrollment (size), focus (liberal arts, sciences, workforce development/training), location (woodlands, desert, frozen tundra, rural reservation, urban), and student population (predominantly American Indian). However, Tribal identity is the core of every TCU, and they all share the mission of Tribal self-determination and service to their respective nations."[17] Though most students attending TCUs identify as Indigenous, all students are welcome, including international students.[18] Two additional institutions are not Title IV-eligible nor accredited by mainstream organizations[19] but are considered "developing" members of AIHEC.[20] It is possible that tribes, as sovereign nations, could have different educational priorities or hypothetically wish to develop differing accreditation standards. However, all current TCUs appear to be either accredited or in the process of obtaining accreditation, which ensures transferability of credits and access to federal financial aid for learners. An Indigenous medical school would need accreditation from a recognized institutional accreditor for it to be eligible for LCME programmatic accreditation. LCME or COCA accreditation currently is required

for the students/graduates to access medical licensing examinations and accredited graduate medical education.

Unique Resource Challenges for Tribal Land

Environmental injustice can result in infrastructure and transportation challenges on tribal lands. The same factors that create difficulties accessing basic needs such as food and health care also create difficult conditions for the development of schools. "For tribes, multiple and cumulative risks and impacts cannot be separated from the historical legacy of land loss. Indigenous nations in the United States have lost 98.9 percent of their historical land base since European settlers began colonizing the continent."[21] The General Allotment Act of 1887 often resulted in reservations placed on more difficult land, with more productive or "high-quality" land taken for non-Indigenous settlement.[22] In some cases, there are also significant location-based health risks from pollution on or near tribal lands, such as uranium exposure from toxic waste either improperly managed or dumped.[23,24]

However, Indigenous communities also have many stories of transcending the harms experienced: "… life on Native American reservations cannot be defined by hardship alone. It is complex, layered, and often misunderstood. While the challenges are real, ranging from poverty and health disparities to underfunded infrastructure, so too are the stories of cultural preservation, grassroots leadership, and community-driven progress."[25]

Creating Pathways to Support Sustainable Development and Operation of an Indigenous-Led Medical School

Below is a brief review of some of the active collaborations that exist between medical schools and tribal nations that could inform the sustainable development and operation of an Indigenous-led medical school. At the time of this writing in January 2026, there are no tribal medical schools (in contrast to tribally affiliated).[26]

Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. At the time of this writing (January 2026), Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation (OSU-COM CN) is the only tribally affiliated medical campus in the nation. The OSU-COM's relationship with the Cherokee Nation deepened over 12 years, eventually leading to the creation of a new college of medicine campus: "In 2006, our medical students started completing clinical rotations at W.W. Hastings Hospital. In 2009, we established a family medicine residency program in Tahlequah. We now have the opportunity to take this partnership to the next level..."[27] Since 2021, the Cherokee Nation has invested more than $440 million to improve and grow the tribe's health care infrastructure in Oklahoma: "Most of the tribal nations have robust health centers… But they are in rural areas, so recruiting physicians can be difficult."[28] This is a persistent problem, and students from underrepresented populations are those most likely to work in those communities.[29],[30] OSU-COM has as high as 16 percent Native American medical school students, compared to the national average of 0.2 percent.[31]

Oregon Health & Science University Northwest Native American Center of Excellence. The Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial five-year grant from the Health Resources and Services Administration (HRSA). The center "works to sustainably address the health care needs of all people by increasing AI/AN representation in the health professions workforce via culturally informed, evidence-based health education programming and research interventions designed for Indigenous health care learners and professionals. NNACoE sits within the Department of Family Medicine and is an institution-

wide resource for AI/AN students and faculty. NNACoE's 12 study initiatives span five critical points along the education continuum, beginning in high school and continuing through early faculty development."[32] Initiatives for high school students were also created via funding from the Indian Health Service Indians into Medicine Program, foundation grants, and state-legislated funds for expanded partnerships with the University of California, Davis and Washington State University.[33]

AMA Collaborations and Wider Medical Education Work. What follows is a brief overview of current work related to the support for Indigenous medical schools, including but not limited to AMA dialogues with existing groups, such as Indigenous School of Medicine (ISOM, isomhealth.com) and the American Indian Higher Education Consortium's Indigenous Health, Education, and Resources Taskforce (IHEART).

Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended existing policies relevant to the important work of improving pathways for Indigenous physicians and communities and developing the physician workforce based on societal needs. This includes updates to Policy H-350.960, "Underrepresented Student Access to US Medical Schools" at the I-25 meeting, stating that "Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the impact of the 1910 report Medical Education in the United States and Canada ("Flexner Report") and the resulting actions by state medical licensing boards and other groups including the AMA, by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others." This now guides further work by the AMA and will be reported on in future documents.

Some of AMA's work in this space also centers around the AMA's Truth, Reconciliation, and Healing Task Force (TRHT),[34] which advised the AMA Board of Trustees related to amelioration of past harms. AMA also has an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs which "provides guidance to the AMA Board of Trustees and AMA management on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients, while also contributing to broader AMA efforts aimed at improving health outcomes for this population."[35] This was created via Advisory Committee on Tribal Affairs D-615.976 and a report is expected at a future HOD meeting.

AMA Board of Trustees Report 31-A-24, The Morrill Act and Its Impact on the Diversity of the Physician Workforce, discussed the history of Indigenous lands appropriated for higher education institutions, called for additional AMA work in collaboration with other relevant organizations related to Indigenous health, and described recent AMA activity, including federal advocacy efforts.

The California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) received a $1.8 million AMA grant through the Reimagining Residency initiative that started in 2019. This network of residency programs serving rural and underserved communities offers elective opportunities to existing medical students, including in tribal health.[36]

More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns School of Medicine for "Evaluation of an Indigenous Approach to Professional Identity Formation through Coaching."[37] AMA staff and the AMA's TRHT task force also led the project planning

and implementation for convenings for Equity and Justice in Medical Education (EJME), with participants from nine organizations, including but not limited to the Association of American Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS). EJME's goals centered participatory trust building between organizations engaged in equitable workforce development strategies responsive to the June 2023 Supreme Court of the United States (SCOTUS) ruling against race as a consideration in holistic review of medical school applications. These convenings led to explorations of best practices for power sharing within collaborative work and a commitment to future collaboration.[38] AMA staff are also working to develop trainings related to population health as well as genocide remembrance and prevention, broad topics that in some areas include information related to Indigenous health for the AMA EdHub. AMA Excellence in Medical Education grants also aim to improve the pathway toward becoming a physician, including for underrepresented groups such as Indigenous learners.

The Robert Wood Johnson Foundation awarded a grant of $999,994 on September 12, 2025, to Indigenous School of Medicine for a timeframe of 8/31/2025 - 8/30/2027, titled "Redefining medical education by centering and incorporating Indigenous voices."[39] One of ISOM's leaders, Dr. Donald Warne, also a leader on the AMA's TRHT task force, emphasizes that current modern medicine is also Indigenous medicine, though often uncredited—citing examples of traditional Indigenous science and medicine like cranial surgery, aspirin, and the field of osteopathic medicine. Stated goals for ISOM include traditional Indigenous medicine men/women/elders on faculty, not just as advisers; incorporating traditional medicines, beliefs, and practices; and for the culture of medical education to be overhauled to be healing rather than traumatizing to the learner.[26] AMA has engaged in dialogues with ISOM leaders at several meetings and conferences, including the most recent Association of American Indian Physicians conference.

DISCUSSION

Although AMA has not historically founded medical schools directly, AMA does serve in a role developing the physician workforce. For instance, alongside the Association of American Medical Colleges (AAMC), AMA jointly sponsors the Liaison Committee for Medical Education (LCME), which accredits allopathic medical schools in the United States. When the resolution that initiated this report was discussed within the HOD, one area of conversation surrounded potential concerns regarding conflicts of interest if the AMA were to have a hand in any particular medical school or schools. Discussions with LCME staff emphasized the firewall between AMA and the LCME regarding accreditation: decisions about accreditation rest solely with the LCME, and no school is given special treatment, regardless of a connection or lack thereof to AMA, just as allopathic medical schools are members of AAMC, the other co-sponsor of the LCME, but AAMC also cannot and does not influence accreditation decisions. AMA is free to pursue any projects it feels would further its mission to promote the art and science of medicine and the betterment of public health and need not avoid collaborative work in this space. Anyone can apply for LCME accreditation, and the same standards are applied to all applicants.

As discussed in several examples above, AMA is engaged in work on Indigenous health and the possibility of Indigenous medical schools. Although the AMA is not an Indigenous-led organization and therefore cannot determine the best path forward for Indigenous-led work, work is in progress to partner with several organizations on "collaborative feasibility assessments, resource development partnerships, and community-guided planning processes" per Policy H-350.960, "Underrepresented Student Access to US Medical Schools." According to AMA Medical Education staff focused on workforce challenges and attending relevant discussions: Indigenous-governed higher education already in existence (i.e., TCUs, Tribal Colleges and Universities) may either be worthwhile models for new medical schools, or, with sufficient resources and if a priority

for respective tribes, may even be places where medical school(s) may form. Indigenous-led discussions center around where there may be greater potential for rotations as well as pathways into graduate medical education for students, an important component of undergraduate medical education. Three specific locations were discussed as possible areas where Indigenous schools of medicine may form, though these details are under development and currently not publicly available. AMA has also been in touch with Canadian Medical Association leadership on the topic of reconciliation and advancing Indigenous health, including discussions of schools.[40]

Beyond any hypothetical schools themselves, as noted above, significant challenges for Indigenous learners begin far before reaching medical school. Therefore, work must also focus earlier, even into early childhood.

RELEVANT AMA POLICY

AMA has several policies related to Indigenous communities and medical education. These are listed in Appendix A.

CONCLUSION

AMA is engaged with and will continue to engage with ways to support its mission to promote the art and science of medicine and the betterment of public health, including Indigenous health and medical education workforce. Though tribally-led medical education institutions must by definition be initiated by Indigenous communities according to their own priorities and needs, AMA continues to engage directly with those leading this work to provide guidance and support where appropriate.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolves 2 and 4, and the remainder of the report be filed:

1. Our AMA convenes a collaborative with Tribal Nations, Tribal Colleges and Universities (TCUs), Indigenous-led medical education organizations, and academic partners to conduct structured feasibility assessments that lead to the development of Indigenous-led medical schools, including infrastructure needs, accreditation pathways, financing models, and governance structures grounded in tribal sovereignty. (New HOD Policy)
2. Our AMA advocates for the development and funding of comprehensive mentorship and pathway programs connecting Indigenous pre-medical students with physician and other mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development. (New HOD Policy)
3. Our AMA encourages collaboration between our AMA, medical schools, TCUs, and community organizations to increase pathways and funding for Indigenous students in medicine. (New HOD Policy)
4. Reaffirm AMA policies H-60.917 “Disparities in Public Education as a Crisis in Public Health and Civil Rights,” H-295.840 “Support for the Establishment of Indigenous-Led Medical Schools in the United States,” and H-350.960 “Underrepresented Student Access to US Medical Schools.” (Reaffirm HOD Policy)

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

1. Our American Medical Association:
    a. considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation.
    b. will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century.
    c. acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with:
    a. the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education.
    b. the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that:
    a. Decrease the educational opportunity gap.
    b. Increase participation in high school Advanced Placement courses.
    c. Increase the high school graduation rate.
4. Our AMA will advocate for universal access to high-quality and affordable childcare and preschool.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
2. Our AMA commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes.
3. Our AMA encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties.
4. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal.
6. Our AMA continues to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

US Physician Shortage H-200.954

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

AMA Support of U.S. Pathway Programs D-200.970
Our American Medical Association supports development of pilot grant programs advised by a diverse body of AMA member physicians, trainees, staff, and allied organization representatives in medicine and public health (i.e., administration; grantee criteria and selection; periodic reporting) that will:

1. Support existing and new pre-K-16 pathway, Science, Technology, Engineering, Math, and Medicine (STEMM), and pre-med programs;
2. Include program goals of scaling organizational grantees' ability to expand their reach among youth, increasing diversity in medicine, achieving health equity, and improving medical education; and
3. Convene a summit among pathway and STEMM programs regarding best practices, collaboration, and strategic planning.

Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840
Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities.

Enhancing the Cultural Competence of Physicians H-295.897

1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
   2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
   3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
   4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
   5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
   6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
   7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

Support Permanent Funding and Expansion of Native Hawaiian Healthcare H-350.933

1. Our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.
2. Our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.
3. Our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and

culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.

4. Our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

Underrepresented Student Access to US Medical Schools H-350.960

1. Our American Medical Association recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population.
2. Our AMA supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, encouraging state and local governments to make quality elementary and secondary education available to all.
11. Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.

3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Indian Health Service H-350.977

The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:
    a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
    b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;

   c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
   d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
   a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
   b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;
   c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing and the level of professional expertise available for consultation;
   d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
   e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and
   f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

AMA Support of American Indian Health Career Opportunities H-350.981

Our American Medical Association policy on American Indian health career opportunities is as follows:

1. Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

Advisory Committee on Tribal Affairs D-615.976

1. Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
2. Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

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COUNCIL ON MEDICAL EDUCATION REPORT 4 – A-26
Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolve 3 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, was referred for study on the following topics:

> RESOLVED (3), that our AMA support initiatives to develop culturally centered medical curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional accreditation that reflect the values and priorities of Tribal communities. (Directive to Take Action)

This report reviews the history and context of physician workforce shortages in Indigenous communities and explores activity and research in the wider medical education community related to culturally centered medical curricula, Indigenous-focused programs, and faculty and leadership recruitment and development. The report also discusses AMA's current work related to Indigenous workforce needs. Programmatic versus institutional accreditation is also defined and discussed, with resources related to both offered.

The report recommends additional AMA policy supporting the development of leadership training programs for Indigenous physicians, encouraging Indigenous faculty and leadership recruitment/retention, developing and disseminating an Indigenous-centered undergraduate medical education (UME) curricular resource with collaboration and guidance from tribal communities, convening an Indigenous Medical Education Design & Partnership Workshop, and advocating for sustainable funding and workforce policies.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-26

Subject: Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States (Res 303-A-25, R3)

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

Resolution 303-A-25, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," was introduced by the Underrepresented in Medicine Advocacy Section (formerly the Minority Affairs Section). The original resolve 1 was amended and adopted becoming Policy H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States." Resolves 2, 3, and 4 were referred. Resolves 2 and 4 will be addressed in CME 3-A-26, with the study of resolve 3 as the focus of this report. This resolve asked the following:

> RESOLVED (3), that our AMA support initiatives to develop culturally centered medical curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional accreditation that reflect the values and priorities of Tribal communities. (Directive to Take Action)

BACKGROUND

The contextual factors informing this report's analysis, namely, persistent physician workforce shortages affecting Indigenous communities and the foundational principles of tribal and Indigenous sovereignty as they relate to health professions education are addressed in detail in CME 3-A-26, Support for the Establishment of Indigenous-Led Medical Schools in the United States. That report provides a comprehensive review of historical, policy, and workforce dynamics that shape the need for Indigenous-led medical education pathways. To avoid duplicating that discussion, this report builds on the established background and focuses specifically on considerations unique to development of culturally centered medical curricula, recruitment of Indigenous faculty and leadership, and facilitation of pathways to institutional accreditation that reflect the values and priorities of Tribal communities.

Existing Activities

Below is a brief review of some of the active collaborations that exist between medical schools and tribal nations regarding culturally centered curricula and/or faculty and leadership development for Indigenous physicians.

Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. The Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation (OSU-COM CN) is the only tribally affiliated medical school campus in the nation. This program offers the following: "The Tribal Medical Track prepares medical students for a primary care residency at tribal facilities and a successful practice in tribal, rural and underserved Oklahoma… [with] unique

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learning opportunities for motivated students to fully develop their skills, knowledge and abilities to succeed in a challenging practice environment while learning about the rich cultures of American Indians."[1]

UC Davis PRIME Tribal Health Pathway. The UC Davis Programs in Medical Education (PRIME) Tribal Health Pathway focuses on recruiting new physicians to serve California's tribal, urban, and rural communities and reduce health inequities, as well as building partnerships with tribal communities, improving training in relevant determinants of health, and building a deeper understanding of self-determination and health advocacy.[2] Indigenous physicians are co-founders of the Huwighurruk post-baccalaureate pathway program, as well as co-directors of the PRIME Tribal Health Pathway,[3] which accepts up to 6 students per academic year.[4]

Oregon Health & Science University Northwest Native American Center of Excellence. The Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial five-year grant from the Health Resources and Services Administration (HRSA). The center "works to sustainably address the health care needs of all people by increasing AI/AN representation in the health professions workforce via culturally informed, evidence-based health education programming and research interventions designed for Indigenous healthcare learners and professionals. NNACoE sits within the Department of Family Medicine and is an institution-wide resource for AI/AN students and faculty. NNACoE's 12 study initiatives span five critical points along the education continuum, beginning in high school and continuing through early faculty development."[5] Initiatives for high school students were also created via funding from the Indian Health Service Indians Into Medicine Program, foundation grants, and state-legislated funds for expanded partnerships with University of California, Davis and Washington State University.[6]

AMA Efforts to Support the Development of an Indigenous Physician Workforce

What follows is a brief overview of current AMA work related to Indigenous health curricula and faculty development. AMA, though it does not play a role in creating specific medical school curricula, does have extensive policy in support of culturally appropriate and evidence-based curricula.

Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended existing policies relevant to the important work of improving pathways for Indigenous physicians and communities and developing the physician workforce based on societal needs. This includes updates to Underrepresented Student Access to US Medical Schools H-350.960 at the I-25 meeting, stating that "Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the impact of the 1910 report Medical Education in the United States and Canada ("Flexner Report") and the resulting actions by state medical licensing boards and other groups including the AMA, by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others." This now guides further work by the AMA and will be reported on in future documents.

Some of AMA's work in this space also centers around the AMA's Truth, Reconciliation, and Healing Task Force (TRHT),[7] which advised the AMA Board of Trustees related to amelioration of past harms. AMA also has an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs which "provides guidance to the AMA Board of Trustees and AMA management

on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients, while also contributing to broader AMA efforts aimed at improving health outcomes for this population."[8] This was created via Advisory Committee on Tribal Affairs D-615.976 and will receive a report in a future HOD meeting.

The California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) received a $1.8 million AMA grant through the Reimagining Residency Initiative that started in 2019. The program trained medical students and resident physicians in seven medical specialties, including internal medicine, family medicine, emergency medicine, general surgery, ob-gyn, pediatrics, and psychiatry at 10 health care systems, 16 hospitals, and a network of Federally Qualified Health Center partners throughout Northern California and Oregon. The goal of COMPADRE was to address health care workforce shortages in rural, tribal, urban, and other communities that lack resources; increase access to health care professionals; and improve the health of patients who are disproportionately affected by certain conditions.

More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns School of Medicine for "Evaluation of an Indigenous Approach to Professional Identity Formation through Coaching."[9] AMA staff and the AMA's TRHT task force also led the project planning and implementation for convenings for Equity and Justice in Medical Education (EJME), with participants from nine organizations, including but not limited to the Association of American Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS). EJME's goals centered participatory trust building between organizations engaged in equitable workforce development strategies responsive to the June 2023 Supreme Court of the United States (SCOTUS) ruling against race as a consideration in holistic review of medical school applications. These convenings led to explorations of best practices for power sharing within collaborative work and a commitment to future collaboration.[10] AMA staff are also working to develop trainings related to population health as well as genocide remembrance and prevention, broad topics that in some areas include information related to Indigenous health for the AMA EdHub. AMA Excellence in Medical Education grants also hope to improve the pathway toward becoming a physician, including for underrepresented groups such as Indigenous learners. The AMA EdHub has other resources available to help faculty develop deeper cultural sensitivity when practicing with Indigenous populations on topics such as: Ethics Talk: Representation, Sovereignty, and Caring for Native American Patients[11] and Disparities in Telehealth Use for Mental Health Care Among American Indian/Alaska Native Veterans.[12] Similarly, JAMA Network hosts relevant resources to increase physician faculty understanding of Indigenous health issues, such as Feasibility of an Indigenous Food Is Medicine Program for Patients With Heart Failure in Rural Navajo Nation.[13]

The Robert Wood Johnson Foundation awarded a grant of $999,994 on September 12, 2025, to Indigenous School of Medicine (ISOM) for a timeframe of 8/31/2025 - 8/30/2027, titled "Redefining medical education by centering and incorporating Indigenous voices."[14] One of ISOM's leaders, Dr. Donald Warne, also a leader on the AMA's TRHT task force, emphasizes that current modern medicine is also Indigenous medicine, though often uncredited—citing examples of traditional Indigenous science and medicine like cranial surgery, aspirin, and the field of osteopathic medicine. Stated goals for ISOM include traditional Indigenous medicine men/women/elders on faculty, not just as advisers; incorporating traditional medicines, beliefs, and practices; and for the culture of medical education to be overhauled to be healing rather than traumatizing to the learner.[15] AMA has engaged in dialogues with ISOM leaders at several meetings and conferences, including the most recent Association of American Indian Physicians conference.

The American Indian Higher Education Consortium's Indigenous Health, Education, and Resources Taskforce (IHEART) is "a national collaborative, formed in 2021 to address the scarcity of American Indian and Alaska Native (AI/AN) communities in the health professions…led by the Association of American Indian Physicians, American Indian Higher Education Consortium, Association of Native American Medical Students, Association of American Medical Colleges, and the Indian Health Service."[16] One IHEART objective is "Develop regional infrastructure to identify educational pathways programs to support and encourage American Indian/Alaska Native students to enter into the health professions workforce." AMA has also been invited to attend and engage in these discussions.

AMA staff was also engaged with some work in this space with Johns Hopkins Center for Indigenous Health,[17] although as of January 14, 2026, five Indigenous health programs at this institution were ended due to federal budget cuts.[18]

Culturally Centered Indigenous Medical Curricula

The Association of American Medical Colleges (AAMC) offers a blueprint for overall cultural competence within medical school curricula, including a tool for assessing its effectiveness.[19] More specific to Indigenous health, AAMC also convenes the Indigenous Health Educators Alliance (IHEAL), a "national collective of scholars and leaders committed to advancing the contribution of Indigenous principles and practices in health professions education and training."[20] This includes publications and resources on how to develop and implement curricula, and is also related to the recruitment and development of Indigenous faculty. Other work has been done in this space, including guiding principles in the development of Indigenous health curricula[21] and research demonstrating the potentially harmful assumptions that must be understood prior to succeeding at truly incorporating Indigenous knowledge into curricula.[22] One study showed that first-year medical students of all identities had improved Indigenous health knowledge, cultural intelligence, ethnocultural empathy, and social justice beliefs immediately after a lecture series and six months later.[23]

In Canada, the National Consortium for Indigenous Medical Education published "Guidelines for the Development of Indigenous Studies, Cultural Safety & Antiracism Assessment in Medical Education" in 2024, and this may be useful within the context of the United States as well.[24]

Indigenous Faculty Recruitment, Development, and Retention

In one publication related to faculty recruitment best practices, the author emphasized, "Residency leadership can benefit from maintaining a mindset that they are always recruiting faculty, even when recruiting students, where mentorship and role modeling efforts can help expand students' imagination of what an academic career can look like."[25] To this point, recruitment and retention of Indigenous faculty can be especially challenging when there are already disproportionate challenges to Indigenous learners even before entering medical school: "American Indian and Alaska Native individuals had a 63% lower odds of applying to medical school… and 48% lower odds of holding a full-time faculty position… compared with their White counterparts, yet had 54% higher odds of working in a residency specialty deemed as a priority by the Indian Health Service."[26] Unfortunately this is a circular problem, as the lack of diverse faculty mentorship also serves as an obstacle for medical trainees who may otherwise be interested in pursuing a career in medicine.[26]

As keynote speaker for the 2024 National Diversity in STEM Conference, Dr. Donald Warne's vision for an Indigenous school of medicine included tribal medicine people as faculty—elders and

healers who are not necessarily exclusively physicians, though physicians would clearly also be important.[27] This corresponds with other research on the importance of respect for Indigenous elders' teachings within health professions education.[28] This may also increase the pool of appropriate mentors for Indigenous physicians. Pragmatic solutions[29] to existing issues—such as funding shortages and threatened layoffs to Indian Health Service physicians[30]—may also be helpful. Organized advocacy also can play a critical supporting role. The AMA conducts advocacy in the areas of GME funding and student loan forgiveness.[31]

Some initial research on best practices in developing existing faculty has been done, noting the importance of Indigenous-specific space, skill building, networking, and ongoing mentorship, "each of which were included to specifically mitigate isolation and tokenism that negatively affects promotion and advancement." Next steps in this research include longitudinal evaluation.[32]

Pathways to Accreditation

One area of the original resolution that was referred for study references facilitating "pathways to institutional accreditation."

AMA policy Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896 does oppose "any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation standards."

For the accreditation of allopathic medical schools in the United States (programmatic accreditation), the Liaison Committee on Medical Education (LCME) publishes a document called "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree," available on their website, describing what is required of a medical school for accreditation. LCME also publishes a Data Collection Instrument for Preliminary Accreditation Surveys, which details the types of questions a new medical school would need to answer in order to work toward preliminary accreditation.[33]

The American Osteopathic Association, specifically COCA, accredits osteopathic medical schools in the United States and also provides accreditation guidelines and policies on their website.[34]

While the administrative process for accreditation of an Indigenous medical school may be similar to any other medical school in regard to the requirements to create a school and seek allopathic or osteopathic accreditation, a tribal medical school may potentially have differences due to a tribe's status as a sovereign nation (see discussion in CME 3-A-26, Support for the Establishment of Indigenous-Led Medical Schools in the United States). Accreditation of medical education programs by the LCME does not grant access low-interest student loans via Title IV funding. Eligibility for this depends on institutional accreditation, which is via national accreditors and differs from specialized accreditation for a specific profession (such as medicine).[35] Many existing tribal colleges and universities (TCUs) already have institutional accreditation, though they do not currently have medical schools.

In terms of institutional accreditation, as of this writing (February 2026), only freestanding colleges of osteopathic medicine are eligible to seek COCA accreditation as a pathway to participation in Title IV programs[36] through one of the six institutional accreditors recognized by the United States Department of Education that covey Title IV eligibility.[36] COCA also provides guidance and resources for new and developing colleges of osteopathic medicine,[37] and the full 2026 COCA

accreditation standards for new and developing colleges of medicine are available on their website.[38]

DISCUSSION

Existing AMA policy and actions do support initiatives to develop culturally centered medical curricula and recruit Indigenous faculty and leadership. However, AMA does not facilitate specific pathways to institutional nor programmatic accreditation, although the AMA can participate in feasibility planning alongside other groups, as discussed above.

RELEVANT AMA POLICY

AMA has several policies related to Indigenous communities and medical education. These are listed in Appendix A.

CONCLUSION

AMA is engaged with and will continue to engage with ways to support its mission to promote the art and science of medicine and the betterment of public health, including Indigenous health and medical education workforce. AMA continues to engage directly with those leading this work to provide guidance and support where appropriate.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolve 3, and the remainder of the report be filed:

1. Our AMA supports the development of leadership training programs for Indigenous physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, health care administration, and public health. (New HOD policy)
2. Our AMA encourages Indigenous faculty and leadership recruitment/retention through an Indigenous Faculty & Leadership Development Initiative in collaboration with AMA Ed Hub. (New HOD policy)
3. That our AMA develop and disseminate an Indigenous-centered undergraduate medical education curricular resource with collaboration and guidance from tribal communities.(Directive to Take Action)
4. That our AMA convene an Indigenous Medical Education Design & Partnership Workshop to advance Indigenous educational principles and partnerships. (Directive to Take Action)
5. That our AMA advocate for sustainable funding and workforce policies that support Indigenous learners, faculty, and clinical training partnerships. (New HOD policy)
6. Reaffirm AMA policies H-295.840 “Support for the Establishment of Indigenous-Led Medical Schools in the United States” and H-350.960 “Underrepresented Student Access to US Medical Schools.” (Reaffirm HOD Policy)

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
2. Our AMA commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes.
3. Our AMA encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties.
4. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal.
6. Our AMA continues to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

US Physician Shortage H-200.954

1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306
Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty.

Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840
Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities.

Enhancing the Cultural Competence of Physicians H-295.897
1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers,

when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896

1. Our American Medical Association opposes any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation standards.
2. Our AMA supports ACGME, COCA, and LCME in advocating for their accreditation standards focused on diversity, equity, and inclusion for the betterment of patient care and public health.
3. Consistent with applicable laws, our AMA supports allopathic and osteopathic medical education accreditation bodies in strengthening accreditation standards focused on diversity, equity, and inclusion.

Support Permanent Funding and Expansion of Native Hawaiian Healthcare H-350.933

1. Our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.
2. Our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.
3. Our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.
4. Our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

Underrepresented Student Access to US Medical Schools H-350.960

1. Our American Medical Association recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population.
2. Our AMA supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.

5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, encouraging state and local governments to make quality elementary and secondary education available to all.
11. Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

<u>Improving Health Care of American Indians and Alaska Natives H-350.976</u>

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.

8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Indian Health Service H-350.977

The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:
    a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
    b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;
    c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
    d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
    a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
    b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;
    c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus

increasing both the available staffing and the level of professional expertise available for consultation;

d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and
f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

<u>AMA Support of American Indian Health Career Opportunities H-350.981</u>
Our American Medical Association policy on American Indian health career opportunities is as follows:

1. Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring

acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.

5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

Advisory Committee on Tribal Affairs D-615.976

1. Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
2. Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-26)

Introduced by: Pennsylvania

Subject: Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies

Referred to: Reference Committee C

Whereas, the ACGME requires all accredited residency and fellowship programs to ensure competency in six core areas: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Systems-Based Practice, Professionalism, and Interpersonal and Communication Skills; and

Whereas, the core competency of Systems-Based Practice requires residents and fellows to demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal care; and

Whereas, the current healthcare system is increasingly shaped by corporate and employed practice models, which limits trainee exposure to the broader range of healthcare delivery systems, including conventional independent private practice, Direct Primary Care (DPC), Direct Specialty Care (DSC), and other innovative models that emphasize patient access, physician autonomy, and cost transparency; therefore be it

RESOLVED, that our American Medical Association will advocate to the ACGME and other relevant accrediting and educational bodies for the formal inclusion and recognition of diverse practice model exposure as a vital component of Systems-Based Practice training. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-26)

Introduced by: Michigan

Subject: Excessive Cost of Multi-State DEA Licensure

Referred to: Reference Committee C

Whereas, many physicians seek licensure in multiple states due to locum tenens work, telehealth work, and/or coverage of patients who seek jobs or education in other states; and

Whereas, many physicians seek medical licensure and Drug Enforcement Administration (DEA) licensure in multiple states to legally provide these services across state lines; and

Whereas, a DEA license is a federal license; and

Whereas, DEA licensure requires a separate application and the full DEA licensure fee for each state in which licensure is desired; and

Whereas, obtaining a multi-state DEA licensure application is inconvenient and expensive despite DEA licensure being a federal (national) license; and

Whereas, the DEA has been encouraging improved access to controlled substances utilized as medications for opioid use disorder to reduce opioid-related overdoses as a federal concern; and

Whereas, the DEA has changed the educational requirements for obtaining an initial or a renewed DEA license to reflect this concern with a one-time attestation for this educational requirement at the federal level; and

Whereas, the time and monetary expense of obtaining DEA licensure in multiple states may limit access rather than encourage access to controlled substances utilized as medications for opioid use disorder; therefore be it

RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, “One Fee One Number D-100.975” and “One Fee, One Number D-100.980.” (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/10/26

RELEVANT AMA POLICY

One Fee One Number D-100.975
1. Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database.

One Fee, One Number D-100.980
Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-26)

Introduced by: Mississippi

Subject: Allowing Options for Certification Maintenance

Referred to: Reference Committee C

Whereas, it is estimated that 25% of physicians plan to leave medicine within 5 years, not necessarily due to retirement age but the burdens of practice; and

Whereas, the national physician shortage is well-known and growing, predicted to be 124,000 by 2034, and Mississippi is currently facing a physician shortage throughout the state; and

Whereas, problems of the current monopoly of Maintenance of Certification (MOC) are a significant emotional burden for the practicing physician and the problems with MOC are multifaceted and include financial burdens, time constraints, questionable clinical relevance, lack of evidence of improved outcomes, increased potential for burnout, and concerns of fairness and equity; and

Whereas, MOC requirements often overlap with state licensure and hospital Credentialing requirements, creating redundancy and unnecessary administrative burdens; and

Whereas, many argue that local hospital credentialing boards are better equipped to assess physician performance within their systems; and

Whereas, MOC requirements and expenses often chase out experienced and highly trained physicians who allow their certification to lapse, which eliminates quality physicians from clinical and hospital care; and

Whereas, burdensome Maintenance of Certification requirements can drive experienced physicians out of practice or out of hospital participation, only to have those physicians replaced in some settings by nurse practitioners and physician assistants whose training is far less extensive than physician training; and

Whereas, separate accreditation and certification systems for these nonphysician practitioners can create confusion and blur critical distinctions in education, clinical preparation, and qualifications; and

Whereas, the MOC monopoly and its associated burdens may therefore contribute to reduced quality of patient care, physician displacement and premature physician retirement; and

Whereas, there is an alternative MOC pathway for board certified physicians, which is the physician-led nonprofit National Board of Physicians and Surgeons (NBPAS), founded in 2015, which is 1) inexpensive 2) requires previous certification through an ABMS (American Board of Medical Specialties)/AOA (American Osteopathic Association) member board 3) requires an

active, valid, and unrestricted medical license 4) requires submission of substantial CME related to specialty 5) requires Active Hospital Privileges (for most specialties); and

Whereas, NBPAS meets national accreditation standards for hospitals and health plans, verifies physician credentials as required, and is accepted by a growing number of hospitals, health systems, telemedicine companies, and other physicians' employers; and

Whereas, two of the largest accreditors in the United States, The Joint Commission and the NCQA both officially acknowledge NBPAS as a "designated equivalent source agency" and "an acceptable source for board certification," respectively; and

Whereas, NBPAS has grown to over 11,000 physicians in all 50 states and provides physicians both competition and choice in continuing certification; therefore be it

RESOLVED, that our American Medical Association encourage all hospitals and insurance programs in the United States to end the monopoly of MOC and accept NBPAS to accomplish any MOC requirements (New HOD Policy); and be it further

RESOLVED, that our AMA request that the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA) accept this alternative route for MOC for all teachers of medical students and physicians in order to maintain quality and experienced instruction in residency programs and medical schools in this era of physician shortages. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-275.926 Medical Specialty Board Certification Standards

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
    a. a process for defining specialty-specific standards for knowledge and skills and
    b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.

4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. [Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19 Modified: Res. 316, I-22 Appended and Reaffirmed: CME Rep. 04, I-23 Reaffirmed in lieu of: Res. 302, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-26)

Introduced by: Mississippi

Subject: Increasing the Use of Retired Physicians in Teaching Students and Residents

Referred to: Reference Committee C

Whereas, in the teaching of medical students and residents, experience plays a significant role in passing on important aspects of patient care and medical treatment; and

Whereas, when physicians retire from active or full practice, they often seek ways to continue to contribute to their communities and profession; and

Whereas, the teaching of medical students and residents is a critical place where retired physicians could continue to contribute their skills and experience to a new generation of physicians and patients; and

Whereas, throughout the country, especially in rural based programs, medical schools and residency programs struggle to find qualified and experienced faculty; and

Whereas, there are often administrative hurdles and roadblocks which prevent retired physicians from fully participating in teaching programs at schools and residencies; therefore be it

RESOLVED, that our American Medical Association explore with the appropriate stakeholders creative and innovative ways to increase opportunities and decrease hurdles for retired physicians to participate fully as medical faculty at medical schools and residency training programs. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-200.972 Primary Care Physicians in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
    a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
    b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
    c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
    d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;

e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:
   a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
   b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas. [CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 724, A-23 Reaffirmed: BOT Rep. 07, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-26)

Introduced by: Mississippi

Subject: Leadership by Physicians for Physicians in Graduate Medical Education (GME)

Referred to: Reference Committee C

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) sets and monitors national standards for residency and fellowship programs, ensuring high-quality graduate medical education (GME) and clinical learning environments across the United States; and

Whereas, GME is a pivotal stage in physician development, shaping lifelong practice patterns, clinical judgment, and professional identity through supervised care, scholarship, and mentorship; and

Whereas, each ACGME-accredited Sponsoring Institution (SI) must designate a Designated Institutional Official (DIO) who serves as the institution's chief GME officer and is responsible for ensuring compliance with ACGME institutional and programmatic requirements; and

Whereas, the role of the DIO has expanded significantly beyond its original scope and now includes oversight of accreditation standards, resident wellness, faculty engagement, NRMP Match strategy, institutional GME policy, and direct interaction with hospital leadership; and

Whereas, unlike ACGME program director standards which require specialty board certification, clinical expertise, and years of documented education experience - the DIO position has no required baseline qualifications, protected time, or minimum FTE support explicitly defined in ACGME Institutional Requirements; and

Whereas, as of 2023, ACGME oversees more than 900 Sponsoring Institutions, and national data shows that approximately 85% of DIOs are physicians, leaving a significant minority filled by non-clinicians with no formal graduate medical education training; and

Whereas, a 2022 survey published in the Journal of Graduate Medical Education found that 92% of program directors and 88% of residents believe the DIO should be a physician with personal experience in graduate medical education, and that physician leadership is essential for institutional credibility, educational alignment, and learner protection; and

Whereas, large academic centers employ physicians as DIOs, but new and rural GME expansion sites, particularly in Mississippi are increasingly placing non-physician administrators into these roles without graduate medical education backgrounds; and

Whereas, national trends show a rising imbalance in healthcare leadership, with approximately 10 administrators per 1 physician in the United States; and

Whereas, physicians who have completed medical education and residency training are best

positioned to understand the complexity, duty, and scope of the training process, and should therefore lead, supervise, and structure medical education programs designed for physicians-in-training; therefore be it

RESOLVED, that our American Medical Association work with the ACGME to examine and strengthen minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-310.912 Residents and Fellows' Bill of Rights

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    a. Adequate financial support for and guaranteed leave to attend professional meetings.
    b. Submission of training verification information to requesting agencies within 30 days of the request.
    c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
    d. Health insurance benefits to include dental and vision services.
    e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
    f. Stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
    a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.
    b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
    c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right t

A. **An education that fosters professional development, takes priority over service, and leads to independent practice.**
   With regard to education, residents and fellows should expect:
   1. A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations;
   2. Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities;
   3. Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value;
   4. 24-hour per day access to information resources to educate themselves further about appropriate patient care; and
   5. Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. **Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.**
   With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. **Regular and timely feedback and evaluation based on valid assessments of resident performance.**
   With regard to evaluation and assessment processes, residents and fellows should expect:
   1. Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work;
   2. To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion;
   3. Access to their training file and to be made aware of the contents of their file on an annual basis; and
   4. Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. **A safe and supportive workplace with appropriate facilities.**
   With regard to the workplace, residents and fellows should have access to:
   1. A safe workplace that enables them to fulfill their clinical duties and educational obligations;
   2. Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit;
   3. Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. **Adequate compensation and benefits that provide for resident well-being and health.**

1. With regard to contracts, residents and fellows should receive:
    a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance.
    b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
2. With regard to compensation, residents and fellows should receive:
    a. Compensation for time at orientation.
    b. Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
3. With regard to benefits, residents and fellows must be fully informed of and should receive:
    a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program.
    b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues.
    c. Confidential access to mental health and substance abuse services.
    d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks.
    e. Leave in compliance with the Family and Medical Leave Act.
    f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. **Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.**
With regard to clinical and educational work hours, residents and fellows should experience:
    1. A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME.
    2. At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. **Due process in cases of allegations of misconduct or poor performance.**
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. **Access to and protection by institutional and accreditation authorities when reporting violations**
With regard to reporting violations to the ACGME, residents and fellows should:
    1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
    2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
    3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. [CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16 Modified: CME Rep. 06, I-18 Appended: Res. 324, A-19 Modified: Res. 304, A-21 Modified: Res. 305, A-21 Modified: BOT Rep. 18, I-21 Reaffirmation: A-22 Reaffirmed in lieu of: Res. 307, I-22 Modified: CME Rep. 05, I-23 Reaffirmed: CME Rep. 02, A-24 Modified: Res. 304, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-26)

Introduced by: Women Physicians Section

Subject: Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows

Referred to: Reference Committee C

Whereas, standardized evaluations in undergraduate and graduate medical education play a central role in determining learner advancement, residency and fellowship selection, remediation, and access to professional opportunities; and

Whereas, studies have demonstrated that narrative language and rating patterns in trainee evaluations may vary systematically by gender, race, ethnicity, socioeconomic status, and personal background, independent of measured clinical competence; and

Whereas, a systematic review of nine studies found that more than half of studies reported differences in evaluation outcomes attributed to gender, including gender-based differences in assessed traits, with female residents receiving more discordant feedback than male residents, particularly regarding assertiveness and receptivity to guidance;[1] and

Whereas, a qualitative analysis of 1,317 emergency medicine PGY-3 resident evaluations demonstrated significant gender-based differences in feedback, with female residents more frequently receiving inconsistent or discordant assessments in which behaviors related to assertiveness and autonomy were more likely to be characterized as aggression or resistance to feedback;[2] and

Whereas, a large retrospective study of approximately 90,000 third-year medical students identified 37 descriptive terms applied differently by gender and 53 terms applied differently by underrepresented-in-medicine (URM) status, with women and URM students more frequently described using personality-based descriptors such as “pleasant,” “nice,” and “lovely”;[3] and

Whereas, bias affecting URM physicians in evaluations was also identified among resident physicians in a large cohort study of 9,026 residents across 305 internal medicine residency programs;[4] and

Whereas, such variation in evaluations can undermine the validity, reliability, and fairness of assessment systems and may contribute to inequities in training outcomes, leadership selection, and workforce retention; and

Whereas, bias in high-stakes evaluations disproportionately affects groups underrepresented in medicine, with negative downstream consequences for the physician workforce pipeline; and

Whereas, the AMA has long supported evidence-based medical education, equitable training environments, and assessment systems that accurately reflect physician competence in order to

promote patient safety and high-quality care, yet a policy gap remains regarding competency-based evaluation practices for interns, residents, and fellows; therefore be it

RESOLVED, that our American Medical Association amend D-295.318 "Competency-Based Portfolio Assessment of Medical Students" by addition and deletion to read as follows:

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student and trainee evaluations, including competency-based portfolio assessment; and be it further

2. Our AMA will work with the NRMP, ACGME and ~~the 11 schools in the AMA's Accelerating Change in Medical Education consortium~~ medical schools to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency and fellowship match process ~~and off-cycle entry into residency programs,~~ and transitions across the UME-GME practice continuum; including off-cycle entry pathways.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" by addition to read as follows:

Our American Medical Association recognizes that implicit biases in evaluations, including those related to gender, race, ethnicity, socioeconomic status, and/or personal background, may influence learner assessment, advancement, and professional opportunities across the medical education continuum;

Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and **implicit bias** and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and **implicit bias** and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and **implicit bias** and microaggressions.
- Establish training requirements for systemic racism, explicit and **implicit bias**, and microaggressions for all members of the healthcare system.

- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and **implicit bias** and microaggressions.
- Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and **implicit bias** and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and **implicit bias** and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and **implicit bias** and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, **bias** or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or **implicit bias** or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

D-295.318 Competency-Based Portfolio Assessment of Medical Students

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.
   [Res. 314, A-10; Appended: Res. 311, A-14; Reaffirmed: CME Rep. 04, A-23]

H-65.961 Principles for Advancing Gender Equity in Medicine

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
[BOT Rep. 27, A-19; Reaffirmed: Res. 604, I-24; Reaffirmed: Res. 606, I-24]

AMERICAN MEDICAL ASSOCIATION ACADEMIC PHYSICIANS SECTION

Resolution: 307
(A-26)

Introduced by: Academic Physicians Section

Subject: Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine

Referred to: Reference Committee C

Whereas, academic medicine has traditionally evaluated faculty for appointment, promotion, and tenure based on clinical excellence, teaching, scholarly activity, and service to institutions and professional organizations; and

Whereas, physician advocacy—including engagement in health policy, community partnerships, public health initiatives, and systems-level improvement—is increasingly recognized as essential to advancing patient care, health equity, and population health; and

Whereas, many medical school promotion and tenure guidelines do not explicitly recognize advocacy activities as a distinct and valued form of academic service, resulting in such efforts being pursued primarily through individual motivation rather than institutional support; and

Whereas, the absence of formal recognition for advocacy work may discourage faculty engagement, contribute to professional dissatisfaction, and undermine the broader mission of academic medicine; and

Whereas, emerging literature supports the importance of building faculty capacity for advocacy and aligning institutional structures to recognize and support these efforts as legitimate academic contributions; therefore be it

RESOLVED, that our American Medical Association reaffirm AMA Policy G-615.103, Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA encourage medical education institutions and academic medical centers to recognize physician advocacy activities as a component of faculty appointment, promotion, and tenure criteria (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant organizations representing medical school leadership, to promote best practices for incorporating advocacy efforts into protected non-clinical faculty effort and academic productivity models. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898

1. Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.
2. Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations. [Res. 309, A-25]

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

1. Our American Medical Association will study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy.
2. Our AMA will study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy.
3. Our AMA will identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.
4. Our AMA will study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences. [Res. 608, A-17; Appended: Res. 617, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-26)

Introduced by: LGBTQ+ Section

Subject: Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development

Referred to: Reference Committee C

Whereas, gender-affirming care (GAC) is recognized as evidence-based medical care by major professional medical organizations, including the American Medical Association[1–11]; and

Whereas, A growing number of states have enacted or proposed legislation restricting or prohibiting the provision of gender-affirming care to minors, and in some cases limiting training in or exposure to such care[12–16]; and

Whereas, recent federal actions, including executive orders, agency directives, regulatory proposals, or funding conditions, have sought to restrict access to or federal support for gender-affirming care, potentially affecting academic medical centers, federally funded training programs, and research institutions[17–20]; and

Whereas, medical education programs, including undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), are expected to provide comprehensive, evidence-based training across the spectrum of patient populations; and

Whereas, restrictions on the provision of gender-affirming care may limit clinical training opportunities for learners in affected states, potentially resulting in variability in competency, preparedness, and accreditation compliance[21–26]; and

Whereas, limitations on clinical exposure may affect recruitment and retention of medical students, residents, fellows, and faculty in states with restrictions on gender-affirming care[27–30]; and

Whereas, disruptions to training in gender-affirming care may have downstream effects on the physician workforce's ability to provide comprehensive care to transgender and gender-diverse patients nationally, which aligns with AMA priorities regarding physician workforce development and preservation; therefore be it

RESOLVED, that our American Medical Association study the impact of federal and state restrictive actions on gender-affirming care on undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), including effects on: (1) clinical training opportunities, (2) accreditation standards and compliance, (3) federal funding streams for medical education and research, (4) faculty recruitment and retention, (5) trainee recruitment, retention, and geographic distribution, (6) academic freedom and curricular integrity, and (7) physician workforce preparedness to provide comprehensive, evidence-based care (Directive to Take Action); and be it further

RESOLVED, that our AMA assess the implications of federal executive actions, agency guidance, regulatory changes, and funding conditions on academic medical centers and training programs that provide or teach gender-affirming care. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage H-295.847
Our American Medical Association will advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization

Referred to: Reference Committee C

Whereas, osteoporosis affects approximately 10 million Americans and contributes to over 2 million fragility fractures annually, resulting in substantial morbidity, mortality, disability, and health care expenditures; and

Whereas, osteoporosis and low bone mineral density are increasingly recognized as important contributors to frailty, impaired mobility, and surgical risk, particularly in spine surgery and other musculoskeletal procedures; and

Whereas, emerging evidence suggests bone health optimization may influence surgical outcomes, hardware stability, fracture risk, rehabilitation potential, and long-term functional outcomes; and

Whereas, current osteoporosis screening recommendations are primarily population-based and may not fully address the needs of patients at elevated risk for musculoskeletal deterioration, spinal deformity progression, or those being considered for complex spine surgery; and

Whereas**,** osteoporosis frequently coexists with sarcopenia and other age-related conditions that collectively contribute to frailty and loss of independence; and

Whereas**,** the American Medical Association House of Delegates has previously recognized the importance of musculoskeletal health through educational and awareness efforts related to sarcopenia and healthy aging; and

Whereas**,** opportunities may exist to further enhance physician and patient awareness regarding osteoporosis prevention, identification, and optimization strategies across specialties including primary care, endocrinology, geriatrics, orthopedics, neurosurgery, and rehabilitation medicine; and

Whereas, the AMA is well positioned to support physician education, interdisciplinary collaboration, and public health awareness efforts even though it does not establish clinical practice guidelines; and

Whereas, increasing awareness of bone health optimization strategies including nutrition, resistance exercise, fall prevention, and appropriate medical management may improve patient outcomes and reduce long-term health care costs; therefore be it

RESOLVED, that our American Medical Association study opportunities to enhance physician education regarding osteoporosis as a component of musculoskeletal health, frailty prevention, and surgical risk optimization (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage development or promotion of continuing medical education (CME), educational resources, or multidisciplinary programming highlighting the relevance of bone health to mobility preservation, healthy aging, and surgical outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase patient and physician awareness of evidence-based preventive strategies for osteoporosis including physical activity, nutrition, fall prevention, and appropriate screening consistent with existing recommendations (New HOD Policy); and be it further

RESOLVED, that our AMA encourage research examining the relationship between bone health and outcomes such as frailty, disability, surgical recovery, and health care utilization (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physician education regarding the role of bone health optimization as part of comprehensive strategies to preserve mobility, reduce disability, and improve functional outcomes in aging populations (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician awareness that clinical decision-making regarding osteoporosis screening and treatment may appropriately incorporate individualized risk assessment, including consideration of patients at elevated risk for musculoskeletal deterioration or those being considered for complex spine surgery, consistent with clinical judgment and existing evidence. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-25.988 Community-Based Falls Prevention Programs
Our American Medical Association will work with relevant organizations to support community-based falls prevention programs [Res. 408, A-15Reaffirmed: CSAPH Rep. 01, A-25]

H-425.997 Preventive Services
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician [OT Rep. A, NCCMC Rec. 31, A-78Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00, Reaffirmed in lieu of Res. 104, A-06Reaffirmation A-07Modified and Reaffirmed: Sub. Res. 101, A-08Reaffirmed: CMS Rep. 03, I-16Reaffirmed: CMS Rep. 03, I-17]

H-425.994 Medical Evaluations of Healthy Persons
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations. [CSA Rep. D, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: CSAPH Rep. 1, A-13Reaffirmed: CMS Rep. 03, I-17]

D-25.997 Addressing Sarcopenia and its Impact on Quality of Life
1. Our American Medical Association supports educational awareness targeting healthcare professionals, caregivers, and at-risk populations to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice.
2. Our AMA supports nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients.
3. Our AMA promotes regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences.
4. Our AMA supports allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities.
5. Our AMA advocates for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions.
6. Our AMA will collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives. [Res. 509, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-26)

Introduced by: California, ACOG, Hawaii, Idaho, Oregon, Washington

Subject: Increasing Capacity and Access to Maternal Health Services in Rural Areas

Referred to: Reference Committee C

Whereas, rural communities already suffering from physician shortages, hospitals closures, less health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality are at even greater risk with the significant $1 trillion in Medicaid and Affordable Care Act (ACA) funding cuts (CBO) recently imposed by Congress through the passage of HR 1; and

Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation Program that provides $50 billion to states to address rural health care challenges; and

Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural physicians and communities is even greater; and

Whereas, while the AMA has extensive policy on improving rural health provider shortages, infrastructure, health care disparities, and access to care, this resolution includes additional specific policies that are warranted to augment AMA's rural health advocacy; and

Whereas, counties that lack maternity care resources, have no hospitals or birth centers offering obstetric care, or have no obstetric providers, are called maternity care deserts, or "OB deserts"; more than half of current rural hospitals in the United States lack a maternity ward and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 700 rural hospitals in 2025 were at risk of closure due to financial problems; and

Whereas, hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, low public and private reimbursement, and declining birth rates. Labor and delivery units are one of the most expensive departments for hospitals to maintain, second only to emergency departments; and

Whereas, a study by the American Journal of Public Health that looked at adverse maternal outcomes in rural and urban areas across the country found that pregnant individuals residing in rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal mortality rates almost twice the rate of individuals in urban areas; and

Whereas, even states with high numbers of OB-GYNs have a geographic maldistribution within states. One opportunity to expand the number of physicians providing maternity care in rural areas is to increase the number of family physicians who provide obstetric care as part of their family practice. Family physicians may complete a Family Practice Obstetrics fellowship and other requirements to become board certified in Family Medicine Obstetrics; and

Whereas, there is a need to creatively engage in efforts to ensure that pregnant patients in rural regions have access to the care necessary to ensure healthy outcomes for both baby and mother; therefore be it

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by evaluating additional ways to increase physicians providing OB-GYN services in shortage areas, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, and increasing ACGME funding, (Directive to Take Action); and be it further

RESOLVED, that our AMA support board certification programs that offer family medicine physician training in obstetric care to expand access to maternal health care services in rural areas (New HOD Policy); and be it further

RESOLVED, that our AMA support expansion of Family Medicine obstetrical care provided by family physicians who are trained and privileged to deliver such services (New HOD Policy); and be it further

RESOLVED, that our AMA support increased funding and prioritization within the National Health Service Corps Rural Community Loan Repayment Program for OB-GYN and family medicine physicians providing obstetric care working in Maternity Care Target Areas (MCTAs). (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access
8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

H-200.954 U.S. Physician Shortages
1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as

women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.
a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

H-465.988 Educational Strategies for Meetings Rural Health Physician Shortages
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association 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.
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:
m. 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
n. 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-26)

Introduced by: Senior Physicians Section

Subject: Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall

Referred to: Reference Committee C

Whereas, rising medical student debt, averaging $212,000 and often over $300,000, places an undue burden financially disproportionately limiting access for medical students unable to assume this debt and thereby which influences specialty choice away from critical fields like geriatrics, pediatrics, internal medicine, and family medicine[1,2]; and

Whereas, a diverse physician workforce representative of society is essential, yet current debt burden hinders young physicians from considering and pursuing lower paying specialties because they are required to pay back large amounts of debt upon graduation; and

Whereas, the U.S. must begin looking at having an essential number of doctors to care for aging patients; and

Whereas, as the U.S. population of older adults rapidly increases with the aging of the baby boomer generation, it is crucial for the nation to swiftly tackle the shortage of physicians needed to provide care for this group; and

Whereas, recent studies show that three-year medical school programs immediately reduce student debt by 25% without compromising resident quality[3,4,5,6,7]; and

Whereas, only a few medical schools currently offer three-year programs, limiting the number of lower income students who can reasonably be expected to apply; and

Whereas, the One Big Beautiful Bill Act (OBBBA), will begin capping federal student loans for medical and professional students at $50,000 per year beginning in July 2026, with a maximum lifetime aggregate limit of $200,000; therefore be it

RESOLVED, that our American Medical Association (AMA) develop a platform supporting a 3-year medical school curriculum in order to help reduce medical student debt and reduce the coming physician shortage (Directive to Take Action); and be it further

RESOLVED, that our AMA, in order to advance equity in the medical profession, work to ensure all specialties—especially primary care—can compete fairly, reduce the looming physician shortage especially those providing care to older patients (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the AAMC and Liaison Committee on Medical Education (LCME) begin steps to ensure that all medical schools offer a 3-year program by 2030 to help reduce student debt. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/16/26

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RELEVANT AMA POLICY

H-200.949 Principles of and Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
[CME Rep.04, I-18; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: Res. 237, I-25]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
    e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
    f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
    g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
    h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
    i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.

g. Adding the ability to refinance Federal Consolidation Loans.
h. Eliminating the cap on the student loan interest deduction.
i. Increasing the income limits for taking the interest deduction.
j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
    g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
    h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
j. Monitor the denial rates for physician applicants to the PSLF.
k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

[CME Rep. 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of : Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24: Reaffirmed in lieu of Res. 224, A-25; Reaffirmed: Res. 308, I-25]

D-305.952 Medical Student Debt and Career Choice

1. Our American Medical Association encourages key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors.
2. Our AMA will monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty.

[CME Rep. 4, I-21; Reaffirmed: CME Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-26)

Introduced by: American College of Legal Medicine

Subject: Advocating for Equitable Application Review in a Single Match System

Referred to: Reference Committee C

Whereas, both Doctors of Osteopathic Medicine (D.O.) and Doctors of Medicine (M.D.) are fully licensed physicians in the United States, completing rigorous, and necessary education and clinical training to practice medicine; and

Whereas, our American Medical Association (AMA) discourages discrimination against medical students, trainees and physicians based on their osteopathic or allopathic training; and

Whereas, our AMA supports equitable access to and fees associated with clinical electives for both osteopathic and allopathic medical students; and

Whereas, the Association of American Medical Colleges (AAMC) Visiting Student Learning Opportunities (VSLO) program provides tools that enable host institutions offering elective rotations to use applicant filters as a management tool that can discriminate by training institution; and

Whereas, in addition to the AAMC application service fees, host institutions can charge enormous fees for clinical rotations, with documented reports of great disparity in host institution fees for D.O. versus M.D. applicants; and

Whereas, a single, unified accreditation system for graduate medical education has been supported by our AMA and fully implemented, signifying that D.O. and M.D. graduates meet the same professional standards and compete for the same residency and fellowship positions; and

Whereas, the professional competence of a student, trainee or physician is determined by a wide array of factors, including academic performance, clinical skills, research, and interpersonal attributes; and

Whereas, the distinction between D.O. and M.D. is irrelevant to the vast majority of graduate medical education curricula and should therefore only be considered in the evaluation of an applicant if a program requires specific training in the osteopathic component (e.g., Osteopathic Manipulative Treatment or Osteopathic Neuromusculoskeletal Medicine); and

Whereas, application platforms, such as the Electronic Residency Application Service (ERAS), provide program directors with built-in software tools to apply filters that automatically screen, sort, or hide applications based on specific criteria, including the applicant's medical degree type; and

Whereas, this mechanism for easy differentiation with the filter allows for simplistic, initial screening and filtering of applicants that may inadvertently exclude highly qualified candidates by prematurely ending the review process based on a single data point; and

Whereas, reliance on the degree designation prevents institutions from conducting a comprehensive review of a candidate's full profile, thereby limiting their access to a diverse and highly qualified pool of physicians and inappropriately affects the osteopathic profession; and

Whereas, adopting equitable, competency-based selection criteria that value clinical excellence and broad professional experience over a single data point is in the best interest of all medical institutions and the patients they serve; therefore be it

RESOLVED, that our American Medical Association collaborate with its partners to advocate for and ensure the removal of filters within clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with its partners to advocate for and ensure the removal of all filters within the residency and fellowship application systems which differentiate between allopathic and osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within clinical elective application, residency and fellowship application systems (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students and H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice. (Reaffirm HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/19/26

RELEVANT AMA POLICY

H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students
H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice
D-310.977: National Resident Matching Program Reform

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-26)

Introduced by: Medical Student Section

Subject: Evaluation of Situational Judgement Tests in Medical School Admissions

Referred to: Reference Committee C

Whereas, medical school applicants face substantial barriers, and the application process itself is becoming increasingly inaccessible to students, being both monetarily and mentally taxing[1-2, 18-19]; and

Whereas, situational judgment tests (SJT) are video- and text-based examinations that evaluate an applicant's judgment and decision-making skills, interpersonal competencies, professionalism, ethics, and empathy[3]; and

Whereas, 64 medical schools require or recommend, two common SJTs in medical school admissions[4-5]; and

Whereas, despite medical students and applicants overwhelmingly calling for greater transparency in admissions processes, medical schools rarely elaborate on how these examinations are used in admissions[6]; and

Whereas, while SJTs may play a role in a holistic admissions process, they do not replace existing, more personal methods of interpersonal evaluations, such as multiple mini-interviews[7]; and

Whereas, holistic evaluation of a candidate is impossible to successfully conduct in a timed SJT[8]; and

Whereas, there is little to no correlation between performance on SJTs and both academic success and likelihood of disciplinary action[9,10]; and

Whereas, SJT scores show significant group differences by race, ethnicity, and gender, and provide only modest predictive value beyond traditional metrics such as MCAT and GPA, raising equity concerns[11-16]; and

Whereas, the AMA itself has encouraged caution when utilizing novel online personality assessments for admission and/or selection for residency and fellowship programs[17]; therefore be it

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to evaluate the utilization of situational judgment tests, and other similar online decision-making assessments in the medical school admissions process and determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/2026

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RELEVANT AMA POLICY

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.
Res. 960, I-17

Increasing Medical School Class Sizes D-295.938

Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education.

Res. 309, A-08 Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:

Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.

Diversity or minority affairs offices at medical schools.

Financial aid programs for students from groups that are underrepresented in medicine.

Financial support programs to recruit and develop faculty members from underrepresented groups.

Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19 Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23 Reaffirmed: CME Rep. 06, A-25

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

Our AMA will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.

Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.

Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening

mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.
CME Rep. 02, I-22 Reaffirmed: CME Rep. 05, A-25

Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844
Our American Medical Association will encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions.
Our AMA will continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions.
Our AMA recommends that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities.
Our AMA recommends that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities.
CME Rep. 03, I-23

Educating Competent and Caring Health Professionals H-295.975
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.
BOT Rep. NN, A-87 Modified: Sunset Report, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-26)

Introduced by: Medical Student Section, LGBTQ+ Section

Subject: Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education

Referred to: Reference Committee C

Whereas, current medical literature demonstrates robust evidence of systemic disparities in diagnostic and treatment delays for female patients compared to their male counterparts across multiple areas of medicine; and

Whereas, in GI medicine, women with IBD have significantly longer diagnostic delays and higher rates of misdiagnosis compared to men despite similar clinical presentations associated with worse patient outcomes[1,2]; and

Whereas, in rheumatology, women have higher rates of misdiagnosis and diagnostic delays when presenting with spondyloarthritis associated with higher rates of disability and more advanced disease, with recent evidence suggesting clinician expectations and documentation biases may contribute to this disparity[3,4]; and

Whereas, in neurology, women hospitalized due to ischemic stroke were less likely to receive standard diagnostic testing/imaging and less likely to be evaluated by a stroke specialist[5]; and

Whereas, cardiology is the field with the most notable differences in diagnostic timeline and treatment interventions for women compared to men, with women more likely to have a missed angina diagnosis despite similar symptoms [8,9]; and

Whereas, women experiencing Acute coronary syndrome (ACS) are more likely to have delays in diagnosis after hospital presentation, are less likely to receive evidence based medication therapy, are less likely to be treated with cardiac catheterization and receive timely reperfusion, are more likely to experience prolonged “door-to-balloon” times, and have increased rates of in-hospital mortality, repeat MI, stroke, and major bleeding[10-14]; and

Whereas, despite coronary heart disease being a leading cause of morbidity and mortality amongst American women, common signs/symptoms that women present with are often described as ‘atypical’[15,16]; and

Whereas, multiple studies have found that describing common female presentations as ‘atypical’ likely contributes to diagnostic and treatment delays, suggesting that this term should be retired from medical education and literature[17-20]; therefore be it

RESOLVED, that our American Medical Association supports discontinuing use of the term ‘atypical’ to describe sex- and gender-based differences in symptomatic presentations in medical education curriculum and reference materials. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

H-410.946 Decreasing Sex and Gender Disparities in Health Outcomes

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. [Res. 005, A-18]

H-295.890 Medical Education and Training in Women's Health

1. Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum.
2. Our AMA does not support the designation of women's health as a distinct new specialty.
3. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served.
4. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training.
5. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs.
6. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development.
7. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards.
8. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy.
9. Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.

[Jt. Rep. CME and CSA, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 01, A-19; Appended: CME Rep. 01, A-23]

H-180.944 Plan for Continued Progress Toward Health Equity

Health equity, defined as optimal health for all, is a goal toward which our American Medical Association will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. [BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, 1-21; Reaffirmed: CMS Rep. 1, 1-23; Reaffirmed: BOT Rep. 30, A-24]

H-525.988 Sex and Gender Differences in Medical Research,

Our AMA:

(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health and sexual and gender minority health research;

(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and

(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;

(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;

(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and

(9) supports and encourages the National Institutes of Health and other grant-making entities to fund

post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. [Res. 80, A-91Appended: CSA Rep. 4, I-00Modified: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 05, A-16Modified: Res. 004, A-23Modified: CSAPH Rep. 04, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section, Hawaii, Washington, Oregon

Subject: Expanding the Native Hawaiian Health Scholarship Program Eligibility

Referred to: Reference Committee C

Whereas, the federal U.S. government has a legal trust obligation to provide quality health care to American Indian and Alaska Native (AI/AN) and Native Hawaiian (NH) populations, as affirmed through treaties, statutes, and executive orders [1-3]; and

Whereas, despite the federal obligation to improve NH health, NH continue to experience disproportionately high rates of chronic disease, including diabetes, cardiovascular disease, and cancer, requiring co-management across specialties, as well as significantly lower life expectancy compared to non-Native populations [4-20]; and

Whereas, data show that NH representation is declining across multiple medical specialties and there are current specialty gaps in Hawai'i's physician workforce [21-22]; and

Whereas, research indicates that racial/ethnic concordance between NH patients and their physicians has been associated with improvements in patient-physician communication, greater time spent with physicians, improved shared decision-making, improved patient understanding of disease risk, improved medication adherence, decreased wait times for treatment, improved preventive health screenings, and decreased implicit bias from clinicians [23-24]; and

Whereas, Native Hawaiian and Pacific Islanders (NHPI) are critically underrepresented in the medical workforce and among medical trainees, with NHPI medical students representing the smallest proportion of any racial/ethnic group in U.S. medical schools (0.4%)[8-9, 21, 25-28]; and

Whereas, to fulfill federal trust obligations and workforce shortages, the Native Hawaiian Health Scholarship Program (NHHSP) was implemented as a part of the Native Hawaiian Health Care System and has been effective in increasing the number of NH primary care health professionals serving NH communities in Hawai'i [29]; and

Whereas, the current eligibility for NHHSP and comparable service scholarships such as the IHS Scholarship exclude NH healthcare trainees planning to pursue primary care who serve diaspora NHs, as well as NH healthcare trainees pursuing specialized fields such as oncology, cardiology, nephrology, and psychiatry, who serve NH patients [10, 27, 29-30]; therefore be it

RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include Native Hawaiian trainees who provide specialized healthcare services. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

H-270.950 Indian Health Service Licensing Exemptions
Our American Medical Association will work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. [Res. 312, A-23.]

D-200.982 Diversity in the Physician Workforce and Access to Care
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-08Reaffirmation A-13Reaffirmation: A-16Reaffirmed: CME Rep. 5, A-21Reaffirmation: Res. 240, A-24Reaffirmed: Res. 308, I-25]

H-295.871 Accelerating Change in Medical Education: Strategies for Medical Education Reform
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. [CME Rep. 13, A-07Reaffirmed: CME Rep. 01, A-17]

D-180.981 Plan for Continued Progress Toward Health Equity
Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. The Board will provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements. [BOT Rep. 33, A-18]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will: Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: inclusion of all medical specialties in need, and service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas...Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties...[CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24 Reaffirmed in lieu of: Res. 224, A-25Reaffirmed: Res. 308, I-25].

H-350.976 Improving Health Care of American Indians and Alaska Natives

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

[CLRPD Rep. 3, I-98Reaffirmed: Res. 221, A-07Reaffirmation A-12Reaffirmed: Res. 233, A-13Reaffirmed: BOT Rep. 09, A-23Modified: CMS Rep. 03, A-24Reaffirmed: Res. 244, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-26)

Introduced by: Resident and Fellow Section

Subject: Addressing Transitions Within GME Regarding Orientation Standards

Referred to: Reference Committee C

Whereas, in 2025, thousands of new trainees entered categorical residency, started advanced residency, and started fellowship; and

Whereas, the official start date of most ACGME programs is July 1 or August 1; and

Whereas, sometimes residents and fellows are unable to start on the official start date including due to visa delays; and

Whereas, incoming fellows are often required to utilize vacation time to go to orientation at the end of their residency; and

Whereas, many incoming fellows are contractually obligated to provide coverage up until June 30th of their last day of residency; and

Whereas, these transitions in training often lead to gaps in salary and necessary benefits for trainees, including but not limited to health insurance; and

Whereas, students who enroll in the school-sponsored health insurance plan at medical colleges such as NYU Grossman School of Medicine, Northwestern University, Emory University School of Medicine and the University of Rochester extend health insurance coverage through the end of June or later of the respective graduate year to accommodate coverage gaps caused by transitions in training; and

Whereas, these logistical challenges create difficulty in transitioning in graduate medical education, especially for those who need to relocate for training; and

Whereas, creating a staggered start date to fellowship following the end of residency would lead to improved transitions between residency and fellowship by allowing incoming fellows adequate time to relocate and onboard at their new institution; therefore be it

RESOLVED, that our American Medical Association study mechanisms for training programs to provide residents and fellows with necessary benefits, including but not limited to health insurance, during transitions in undergraduate and graduate medical education (Directive to Take Action); and be it further

RESOLVED, that our AMA study the benefits of flexible start dates as it relates to reducing logistical and financial burdens on trainees, including but not limited to the following transitions: (1) from medical school to residency; (2) from a transitional or preliminary year to residency; and (3) from residency into fellowship. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:

a. Adequate financial support for and guaranteed leave to attend professional meetings.
b. Submission of training verification information to requesting agencies within 30 days of the request.
c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
d. Health insurance benefits to include dental and vision services.
e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
f. Stronger due process guidelines. […]

[CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24; Modified: Res. 304, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-26)

Introduced by: Resident and Fellow Section

Subject: Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

Referred to: Reference Committee C

Whereas, interns, residents, and fellows serve in frontline roles that are critical to patient care, including last-minute coverage of inpatient services, consults, rounding, clinics, overnight call, home call, and operating room time when colleagues are unavailable due to unexpected leave, illness, or emergencies; and

Whereas, this coverage system, often referred to as “jeopardy,” typically relies on interns, residents, and fellows from elective rotations to absorb colleagues’ clinical responsibilities, thereby adding significant unplanned workload and stress; and

Whereas, surgical trainees, in particular, may bear a disproportionate jeopardy burden compared to non-surgical trainees due to limited backup and operative coverage, often having to manage additional patients on service while simultaneously covering operative responsibilities, amplifying risk to both trainees and patients; and

Whereas, jeopardy coverage among interns, residents, and fellows may also be utilized to accommodate increased patient volume; and

Whereas, an analysis of 31 institutions found that hospital medicine jeopardy systems contribute to physician dissatisfaction due to their unpredictability, highlighting the potential of equitable compensation models as a solution[1]; and

Whereas, certain residency and fellowship programs require shift “payback” for jeopardy coverage (such as using days off and/or vacation to compensate for sick leave), a practice that exacerbates burnout by discouraging appropriate use of sick time, incentivizing physicians to work while ill, and risking violations of duty hour regulations, thereby undermining physician well-being and patient safety in direct conflict with Accreditation Council for Graduate Medical Education (ACGME) policy 6.14.b[2]; and

Whereas, jeopardy assignments impose additional burdens on interns, residents, and fellows, disrupting essential rest and recovery, limiting time for family and personal health needs, and undermining overall well-being and work-life integration due to unpredictability of call-ins; and

Whereas, there is precedent for jeopardy pay, such as at the University of California, San Francisco Department of Surgery, where jeopardized residents are compensated at the standard moonlighting rate, and at the Stanford Department of Medicine, where internal

medicine residents receive $2,500 for a day shift and $3,000 for a night shift related to patient-volume jeopardy;[3] and

Whereas, the ACGME has increasingly emphasized physician well-being, yet current compensation structures fail to recognize the additional professional, personal, and familial strain associated with jeopardy assignments;[2,4] and

Whereas, ACGME policy 6.14.a. states, "the program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care," but does not require equitable compensation; and

Whereas, a fair and equitable system would provide monetary compensation to interns, residents, and fellows for being "jeopardized" to cover essential shifts, recognizing that the costs of burnout, fatigue, and potential patient safety risks far outweigh the financial impact of jeopardy pay; therefore be it

RESOLVED, that our American Medical Association supports standardized compensation ("jeopardy pay"), provided in addition to base salary and benefits, for interns, residents, and fellows who are required to cover unscheduled ("jeopardy") shifts or additional duties, and encourages programs to adopt transparent and equitable compensation structures that account for specialty-specific burdens. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

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3. UCSF Department of Surgery Resident Portal. https://surgeryresidentportal.ucsf.edu/resident-jeopardy-policy-guidelines
4. Accreditation Council for Graduate Medical Education. ACGME Answers: ACGME's Commitment to the Health and Well-Being of Health Care Professionals. ACGME. Published February 15, 2023. Accessed September 8, 2025. https://www.acgme.org/newsroom/blog/2023/acgme-answers-acgmes-commitment-to-the-health-and-well-being-of-health-care-professionals/

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: Adequate financial support for and guaranteed leave to attend professional meetings. Submission of training verification information to requesting agencies within 30 days of the request. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period. Health insurance benefits to include dental and vision services. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year. Stronger due process guidelines. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24; Modified: Res. 304, I-24]

Principles for Graduate Medical Education H-310.929
COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be

informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
[CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22]

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. [Res. 208, I-22]

Reference Committee D

Report(s) of the Board of Trustees

17 Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
29 Educational Materials Regarding Ultra-processed Foods

Report(s) of the Council on Science and Public Health

01 Sunset Review of 2016 House Policies
02 Setting Standards for Forensic Toxicology Laboratories Used in Litigation
03 Public Health Implications of Food Subsidies
04 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
05 Removing Artificial Turf in Schools, Parks, and Public Places
06 Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
10 Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

Resolutions

401 Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
402 Strengthening Public Health Protections Against Raw Milk–Associated Illness
403 AMA's continued support for COVID-19 vaccination in pregnant individuals and children
404 Develop Climate-Conscious Resources for Physicians
405 Studying the Environmental Impact of Ambient Clinical Intelligence Use
406 Reduce Environmental Impact of Medical Journals
407 Colorectal Cancer in Alaskan Native Patients
408 Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
409 Eliminate PFAS and Glyphosate in our Food and Environment
410 Light Pollution
411 Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
412 Guiding Principles of Pandemic Prevention, Preparedness and Response
413 Erosion of the Public Evidence Base for Health Policy
414 Restoring Balanced Scientific Perspective within the ACIP
415 Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
416 Clinical Laboratory Workforce Shortage and Sustainability
417 Respiratory Protection for Wildland Firefighters
418 Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
419 Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
420 Expanding Support for Women Experiencing Homelessness

421 Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
422 Expanding Access to High Resolution Anoscopy
423 Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
424 Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
425 Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
426 Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")
427 Infant Feeding Options for HIV-Seropositive Individuals
428 Protecting Environmental Health Before, During, and After War
429 Adolescent Dating Violence Comprehensive Screening Tool Development
430 Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
431 Supporting Transportation Infrastructure Reform for Public Health
432 Addressing Public Health Risks of Online Sports Betting
433 Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment
434 Vaccinations in Physician Offices

REPORT OF THE BOARD OF TRUSTEES

BOT Report 17-A-26

Subject:	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee D

BACKGROUND

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

> RESOLVED that our AMA support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index; and be it further
>
> RESOLVED that our AMA support research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers.

DISCUSSION

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

Blood pressure naturally varies throughout the day, from the time a person wakes up in the morning through sleeping overnight, due to factors including environmental circumstances, physical activity, and emotional stress. Blood pressure variability (BPV) refers to these changes in blood pressure that occur over different time periods.[3,4] Excessive long-term blood pressure variability is suggested to be defined as variation in measurements greater than 12 mm Hg, determined by deriving the standard deviation of ideally 6-7 or more clinic-based BP measurements, but this has been debated among scientific scholars.[5,6] Long term variability has

been defined as clinic visit-to-visit variability, over months or years, and can be influenced by factors such as time of year (seasonal variability) and vascular stiffness. Very short-term variability occurs beat-to-beat, short-term variability occurs over a 24-hour period, and mid-term variability is defined as variability seen day-to-day (or between days).[7,8] Blood pressure variability can be calculated using standard deviation, the coefficient of variation, or variance, independent of the mean. The coefficient of the mean can be calculated by dividing the standard deviation by the mean blood pressure.[9]

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

There is growing recognition of blood pressure variability as an important cardiovascular risk factor and BPV can act as a predictor of cardiovascular risk independent of average blood pressure, however it is not currently included in standardized management guidelines as a therapeutic target.[11] It has been suggested that future research is needed to better understand the pathophysiology of target-organ damage and to define the physiological and pathological ranges of BPV.[12]

Electronic Health Record Integration of Blood Pressure Variability

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

Lifestyle Approaches to Reduce Blood Pressure Variability

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

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

Medication

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

AMA Commitment to Reducing the Burden of Chronic Diseases

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

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

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

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

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

Existing AMA Policy

Pharmacist in Hypertension Screening H-425.998
(1) Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel,

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

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

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

Medical Evaluation of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

CONCLUSION

This report highlights the current known association of blood pressure variability with

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

RECOMMENDATION

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

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

Fiscal Note: Significant Fiscal Impact

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

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 29-A-26

Subject: Educational Materials Regarding Ultra-processed Foods

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee D

At the 2025 Annual Meeting of the American Medical Association (AMA) House of the Delegates (HOD), the first Resolve of 601-A-25 was adopted while the second was referred, which asked that:

> Our AMA work with select organizations in the HOD to develop patient educational materials in English and Spanish with regards to the health impact of ultra processed foods as well as pathways for personal dietary options as alternatives to ultra processed foods; and, that such developed materials will be provided by the AMA to members who request them for distribution to their patients.

BACKGROUND

An overwhelming majority of food in our modern society has been 'processed' to some degree (e.g., through fermentation, pasteurization, milling, or refining) but ultra-processed foods (UPFs) represent a category of food that are produced almost entirely from industrially processed ingredients. UPF are generally considered foods that are made with "formulations of ingredients, mostly of exclusive industrial use, that result from a series of industrial processes."[1] While there is not a single standard definition of "ultra-processed," the NOVA classification system, a system created by Brazilian nutrition researchers in 2009 that defines foods as ultra-processed based on the level of industrial processing the foods are subjected to, is among one of the most influential (see Appendix to view the different categories of processed food under the NOVA classification system).[2]

UPFs do not represent a 'new' dietary product, but in fact have been a growing component of the food system since World War II. During the war, there were important advances made in food technology and packaging, which accelerated the distribution of processed food which helped prevent starvation for many at the time.[3] Following the war, UPFs were introduced and heavily advertised to the American public.[3] Almost immediately following the introduction of UPFs, there were concerns raised among some physicians about the nutritional quality of these foods and how they could impact health.[3] These concerns have grown over the last thirty years.[3] For example, the number of research papers mentioning UPFs published between 2021 to 2023 increased by over 300 percent compared to the period between 2017 and 2020.[3]

Public health concerns over UPFs are driven by the fact that they are made with little to no whole food ingredients and are produced through numerous industrial processes that can reduce the nutritional value of the product or introduce harmful elements.[4] UPFs also frequently contain large amounts of sodium, sugars, and saturated fats, which have negative health impacts in their own right, as well as artificial colors and other additives to make them more palatable and increase their shelf life.[5] Examples of UPFs include packaged snacks, mass-produced baked goods, breakfast

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'cereals,' hot dogs, sausages, pre-prepared pasta and pizza dishes. The following discussion summarizes the evidence on health risks associated with UPF consumption, as well as challenges for research in this area, followed by an overview of available educational resources on UPFs for both patients and physicians.

DISCUSSION

Health Impacts of UPF Consumption

Currently, UPFs make up a substantial share of the American diet, and their consumption has grown over time. UPFs have gained prominence in the modern diet due to their affordability, extended shelf life, and convenience.[6] The consumption of ultra-processed foods has grown from 53.5 percent of calories since 2001-2002 to 57 percent in 2017-2018, while the consumption of whole foods has decreased by a similar percentage over the same period.[7] A study looking at data from August 2021–August 2023 found that 55 percent all calories consumed by Americans age one year and older are from UPFs (as defined under the NOVA system).[8] Among youth ages 1–18, the share of calories consumed from UPFs is even higher (61.9 percent).[8] Research has also shown that child-oriented marketing strategies, such as compelling graphic elements (i.e., bright colors); promotional, licensed, or cartoon characters; celebrity endorsers; sportspersons; graphic references to fun and play; and premium collectible offers with toys and child-friendly lettering, are commonly used on labels of UPFs, making them more desirable for young children.[9]

That UPFs constitute such a high proportion of the American diet is a serious concern given the growing evidence showing an association between UPFs and poor health. UPFs, as defined under the NOVA system, are associated with a wide range of health conditions.[10] A 2025 review of the available evidence on UPFs noted plausible mechanisms for adverse health impacts include "nutrient imbalances, overeating, reduced consumption of health-protective phytochemicals, toxic contaminants from processing or packaging, harmful additives and mixtures of additives, and subsequent inflammation, dysglycemia, dyslipidemia, microbiome dysbiosis, and renal or liver dysfunction."[4] Two recent systematic reviews have reported that consumption of UPFs across children and adults is associated with poor health outcomes, such as obesity, cardiovascular disease, and other diet-related diseases, as well as discrepancies across demographic groups that put certain Americans at an elevated risk of high intake and therefore chronic disease.[11,12] Additionally, several epidemiological studies have suggested that increased UPF intake increases the risk of developing chronic kidney disease and accelerates the disease progression.[5] A population based cohort study also found higher consumption of UPFs was associated with an increased risk of all-cause mortality, with greater consumption of certain food groups, such as processed meats and sugar sweetened beverages, demonstrating the strongest associations.[10,13]

Additionally, research has demonstrated an increased risk of certain cancers with increased UPF consumption. A meta-analysis and systematic review found that high UPF consumption, when compared to low UPF consumption, was associated with a significantly increased risk of certain site-specific cancers, particularly of the digestive tract and some hormone-related cancers, but there were differences in risks between genders.[14] More research is needed to better understand the potential causal pathways. Lastly, there is emerging research connecting greater UPF consumption to risks of cognitive decline and impairment as well as stroke.[15–17]

Research on UPFs has seen increased consistency in terms of defining UPFs since the introduction of the NOVA classification system in 2009, but challenges remain. Researchers have noted challenges with the NOVA classification system, including ambiguity, inconsistency in application, and the assignment of foods with nutritional value to the "ultra-processed" category.[18] For

example, a 2024 study found that higher intake of *certain* UPFs were consistently associated with higher all-cause mortality, particularly the UPF subgroups of meat/poultry/seafood based ready-to-eat products, sugar sweetened and artificially sweetened beverages, dairy based desserts, and ultra-processed breakfast foods.[13] However, there are foods, such as some yogurts made with fruit or granola, some milk alternatives, packaged whole grain bread, that are categorized as UPFs but still offer nutritional value.[19] This highlights that there may be important heterogeneity within different subgroups of foods categorized as UPFs in terms of their impact on health and some UPFs can s. Additionally, a recent review article noted the strength and credibility of evidence for many of UPF studies was either low and suggestive/weak.[10]

UPFs and the U.S. Dietary Guidelines

The 2025 Dietary Guidelines Advisory Committee's first print of their scientific report on the American Dietary Guidelines was the first time UPFs were included as a review topic and they stated there was limited evidence on the health impacts of UPFs to make definitive recommendations on its intake.[20] Instead, they recommended more research to inform future iterations of the guidelines. The new U.S. Dietary Guidelines for Americans, released in January 2026, makes a more definitive recommendation against eating highly processed foods, but avoids the term UPF. "Avoid highly processed packaged, prepared, ready-to-eat, or other foods that are salty or sweet, such as chips, cookies, and candy that have added sugars and sodium (salt)…Limit foods and beverages that include artificial flavors, petroleum-based dyes, artificial preservatives, and low-calorie non-nutritive sweeteners."[21] The U.S. Food and Drug Administration (FDA) and U.S. Department of Agriculture (USDA) released a Request for Information in the summer of 2025 to help develop a more unified and consistent definition of UPFs.[22]

Nutritional Literacy and Public Awareness of UPF Risks

In general, the U.S. population has low nutrition literacy, which is defined as "the degree to which individuals have the capacity to obtain, process, and understand nutrition information and skills needed in order to make appropriate nutrition decisions," with one estimate noting that just over one-third of adults have adequate nutrition literacy.[23,24] The Health Belief model suggests that the more people know about the risks of certain foods influences their eating behavior.[25] Having greater nutrition literacy has been correlated with better understanding of nutritional labels and healthier food decisions and thus improving nutritional literary in the general population has the potential to improve dietary choices and overall health.[24,26]

A literature search on U.S. public perceptions and knowledge on UPFs produced limited results. Outside of the U.S., studies on this issue have been largely limited to South American countries and more recently the United Kingdom (U.K.) and other countries in Europe. A study from the U.K. found that while most participants were aware of the term UPF, most could not accurately categorize whether foods were UPFs or not. There were important differences between participants with higher incomes and higher levels of education who were more likely to report both being aware of and avoid consuming UPFs.[27] A study on consumer perceptions and intake of UPFs found participants exposed to information on the negative health impacts of UPF reported increased concerns about consuming UPFs (relative to the control) but there was limited evidence that the acceptability of consuming UPFs was reduced.[26] In essence, while education on UPF increased concerns about UPFs, it didn't necessarily result in behavioral change in terms of UPF consumption. While public education on UPFs will likely affect consumer perceptions of UPFs, it may not impact immediate food intake.[26]

Additionally, physicians have historically lacked sufficient nutritional education or training to be able to provide high-quality, effective nutrition counseling despite recognition within the medical community about the importance of dietary behaviors for health.[28] However, awareness of the potential health risks associated with UPFs has grown and there has been increased attention from medical and public health organizations.[29,30] Additionally, the Make America Healthy Again 2025 report identifies poor diet and the growth of UPFs in the American diet as major concerns for childhood chronic disease.[31] The accompanying strategy document calls for the acceleration of federal efforts to address UPFs.[32] However, public awareness and understanding of UPFs may be exacerbated by the lack of clear labeling, regulatory standards, or educational resources to inform consumer choices with respect to UPFs.

Patient Information on UPFs

A scan of federal agency and health care organization websites as well as a search on PubMed for examples of educational materials on UPFs produced few results. While the USDA and the Department of Health and Human Services (HHS) both have repositories of nutrition-related printable materials and handouts, neither have resources specific to UPFs.[33] Most of these materials and handouts appear to only be available in English. While not specific to UPFs, the FDA has a social media toolkit for their Nutrition Facts Label Campaign, which is intended to help consumers make better informed decisions regarding food choices.[34] The FDA is also proposing to require a front-of-package nutrition label on most packaged foods to provide accessible, at-a-glance information on added sodium, sugar, and saturated fats to help consumers quickly and easily identify which foods are part of a healthy diet.[35] As UPFs generally contain a high amount of these three ingredients, this type of front-of-package label could be very helpful for consumers in identifying unhealthy UPFs.

One article addressed the development of UPF infographics for patients with chronic kidney disease, as UPFs can worsen blood pressure and glycemic control, and lead to constipation, hyperkalemia and hyperphosphatemia.[5] It is unknown whether the education materials referenced in this study have been widely distributed within or outside of this specific patient population. An example of one of the infographics from this paper is provided in Figure 1.

More commonly, health care systems and medical organizations have created dedicated webpages on UPFs. For example, the AMA, as part of their What Doctors Wish Patients Knew™ series, has published an informational page on UPFs.[36] Similarly, the American Heart Association has on their website, "Top Things to Know: Ultraprocessed Foods and Their Association with Cardiometabolic Health."[37] Health care organizations, like the Mayo Clinic and Massachusetts General Hospital (just to name a few), have also created webpages to improve patient education (See Figures 2 and 3).[38,39]

Physician Education and Resources on UPFs

Similar to patient resources, there are limited educational resources on UPFs for physicians. One of the leading organizations for physician education on nutrition is the Gaples Institute, an educational nonprofit dedicated to advancing the role of nutrition and lifestyle in medicine through education and advocacy.[40] While educational content from the Gaples Institute is featured and available on AMA's Ed Hub, they do not have educational content specifically on UPFs, even if some of their existing modules address them. As the Gaples Institute is a well-known provider of physician nutrition education, they could be an important organization to partner with on future clinician educational resources.

Although not specific to UPFs, available nutrition education on AMA's Ed Hub includes:

- Nutrition and Health – CME Course
- 2025 Update — Nutrition Science for Health and Longevity: What Every Physician Needs to Know from the Gaples Institute Nutrition and Lifestyle Education
- Heritage Diets: Adapting Nutrition Recommendations Across Cultures
- Talking to Patients About Using the Nutrition Facts Label to Make Healthy Food Choices (developed in collaboration with the FDA) – CME module

A scan of available nutrition education for physicians produced limited resources on UPFs but also included examples of 'Food is Medicine' courses or nutrition science courses. A few examples of nutritional education from other medical institutions and organizations are provided below:

- The Exam Room™ Podcast on processed foods featuring Dr. Neal Barnard, President of Physicians Committee for Responsible Medicine[41]
- The American Academy of Family Physicians has a publication entitled: Nutrition Myths and Healthy Dietary Advice in Clinical Practice[42]
- The American College of Lifestyle Medicine has multiple 'Food as Medicine' educational courses[43]
- The Stanford Center for Health Education has a Nutrition Science Online Short Course[44]

STATE AND FEDERAL LEGISLATION

Several states have adopted or are considering legislation that bans or prohibits UPFs, with California being the first to pass a law limiting UPFs from schools in October 2025.[45,46] As part of these efforts, the challenge of defining UPFs has been evident, and different states have taken different approaches to define unhealthy UPFs.[47] California's law is the first to create a statutory definition of UPFs, which is defined as:

An ultra-processed food contains one or more of the following:

- Surface-active agents
- Stabilizers and thickeners
- Propellents, aerating agents and gases
- Colors and coloring adjuncts
- Emulsifiers and emulsifier salts
- Flavoring agents and adjuvants
- Non-nutritive sweeteners [D-sorbitol, erythritol, hydrogenated starch hydrolysates, sucralose, isomal, lactitol, luo han fruit concentrate, maltitol, steviol glycosides, thaumatin, xylitol)

AND contains one or more of:

- Saturated fat at 10% or more of calories
- A ratio of mg sodium to calories of more than 1:1
- Sugars at 10% or more of calories[48]

There have also been a few pieces of legislation proposed at the federal level in 2025 and 2026. First introduced in December 2025 and reintroduced in January 2026, the Childhood Diabetes Reduction Act (H.R. 6294/S. 4195) is a bipartisan bill that would require the FDA to implement clear, front-of-package warning labels on foods high in sugar, salt, and saturated fat, or that are classified as a UPF.[49] The proposed bill also aims to restrict marketing of these products to children and directs the NIH to expand research on the harmful additives within them.[50] In the context of this bill, UPFs are defined as, "a food, including a beverage, containing one or more industrial

ingredients, including surface-active agents, stabilizers and thickeners, propellants, aerating agents and gases, color and coloring adjuncts, emulsifiers and emulsifier salts, flavoring agents and adjuvants, flavor enhancers, surface-finishing, non-sugar sweeteners, and other ingredients, as the Secretary [of HHS] determines appropriate."[50] Additionally, in April 2025, the Healthy Lunch for Healthy Kids Act (H.R. 2530) was introduced which aims to amend the National School Lunch Act to prohibit the serving of specific ultra-processed foods, including those containing artificial dyes, titanium dioxide, and other additives in school cafeterias.[51]

CURRENT AMA POLICY AND ACTIVITIES

In the past several years, the AMA has been actively engaged on the issue of UPFs. AMA Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods", directs the AMA to support and promote public health awareness and education about the differences between healthful and unhealthful UPFs, alluding to the existing tensions on defining UPF and whether all UPFs should be considered unhealthy and discouraged. In addition, AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," directed AMA to offer food options of minimally processed fiber-rich foods at AMA-sponsored receptions or meals.[52]

In a February 2025 letter commenting on the Scientific Report of the 2025 Dietary Guidelines Advisory Committee, the AMA urged the Agencies to include more concrete recommendations regarding UPFs.[53] In September 2025, the AMA sent a letter in response to an FDA Request for Information to help develop a uniform definition of UPFs for human food products in the U.S. food supply. In the letter, it was recommended that the definition of UPFs be developed with the primary goal of improving public health and reducing chronic disease.[54] Lastly, the AMA is in the process of organizing a four-part webinar series for 2026 that will engage physicians, residents and medical students in evidence-based education, aligned with HOD policy, on what constitutes a healthy diet, how different dietary patterns impact overall health and how to talk with patients about their dietary choices. As part of this series, at least one of the webinars will cover processed foods.

CONCLUSION

There is a dearth of available educational resources and materials on UPFs, for both patients and physicians. In some respects, this can be attributed to ongoing inconsistencies of how to define UPFs but there is growing evidence that increased UPF consumption has negative health outcomes. As there are current federal efforts underway to develop a more unified and consistent definition of UPFs, it may be prudent for the AMA to focus on lower cost educational options until there is more clarity on the UPF definition. However, as an organization, AMA should continue to support the development of patient materials that help them make healthier dietary choices and improve their health.

RECOMMENDATIONS

The Board of Trustees recommends:

(1) That the second resolve of Resolution 601-A-25 not be adopted; and

(2) That Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods" be amended by addition and deletion to read as follows:

1. Our AMA supports and promotes ~~public~~ awareness and education, among both the public and clinicians, about the differences between healthy~~ful~~ and unhealthy~~ful~~ ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.

2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.

~~2.~~ 3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.

~~3.~~ 4. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.

~~4.~~ 5. Our AMA supports increased funding ~~to the FDA~~ for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Fiscal Note: Between $1,000 - $5,000

APPENDIX

Table 1: NOVA Classification of Foods[1]

Category and Name	Definition
Group 1 – Unprocessed or minimally processed foods	Unprocessed foods or minimally processed foods that are altered by processes such as removal of inedible or unwanted parts, drying, crushing, grinding, fractioning, roasting, boiling, pasteurization, refrigeration, freezing, placing in containers, vacuum packaging or non-alcoholic fermentation. None of these processes add salt, sugar, oils or fats, or other food substances to the original food.
Group 2 – Processed culinary ingredients	These are ingredients obtained directly from group 1 foods or from nature, like oils and fats, sugar and salt. They are created by industrial processes such as pressing, centrifuging, refining, extracting or mining, and their use is in the preparation, seasoning and cooking of group 1 foods.
Group 3 – Processed foods	This category represents food products made by adding salt, sugar or other substance found in group 2 to group 1 foods, using preservation methods such as canning and bottling, and, in the case of breads and cheeses, using non-alcoholic fermentation. Food processing here aims to increase the durability of group 1 foods and make them more enjoyable by modifying or enhancing their sensory qualities.
Group 4 – Ultra-processed food and drink products	Food made from industrial formulations, typically with five or more and usually many ingredients. Such ingredients often include those also used in processed foods, such as sugar, oils, fats, salt, anti-oxidants, stabilizers, and preservatives. Ingredients only found in UPF products include substances not commonly used in culinary preparations, and additives whose purpose is to imitate sensory qualities of group 1 foods or of culinary preparations of these foods, or to disguise undesirable sensory qualities of the final product.

Figure 1 – Educational Materials Developed for Patients with Chronic Kidney Disease[5]

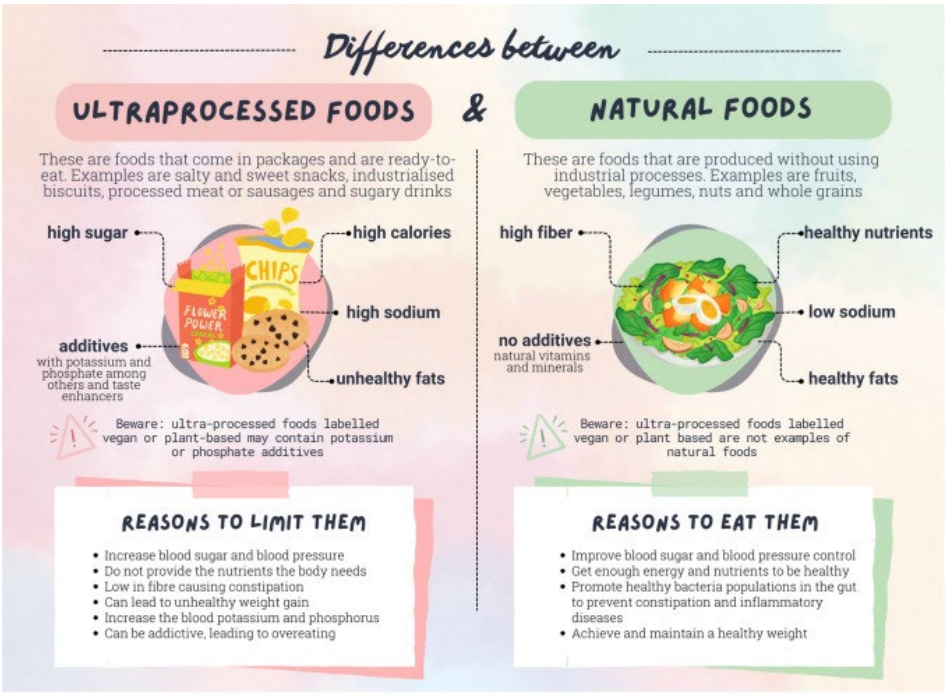


Figure 2 – Patient Education Webpage from Massachusetts General Hospital[39]

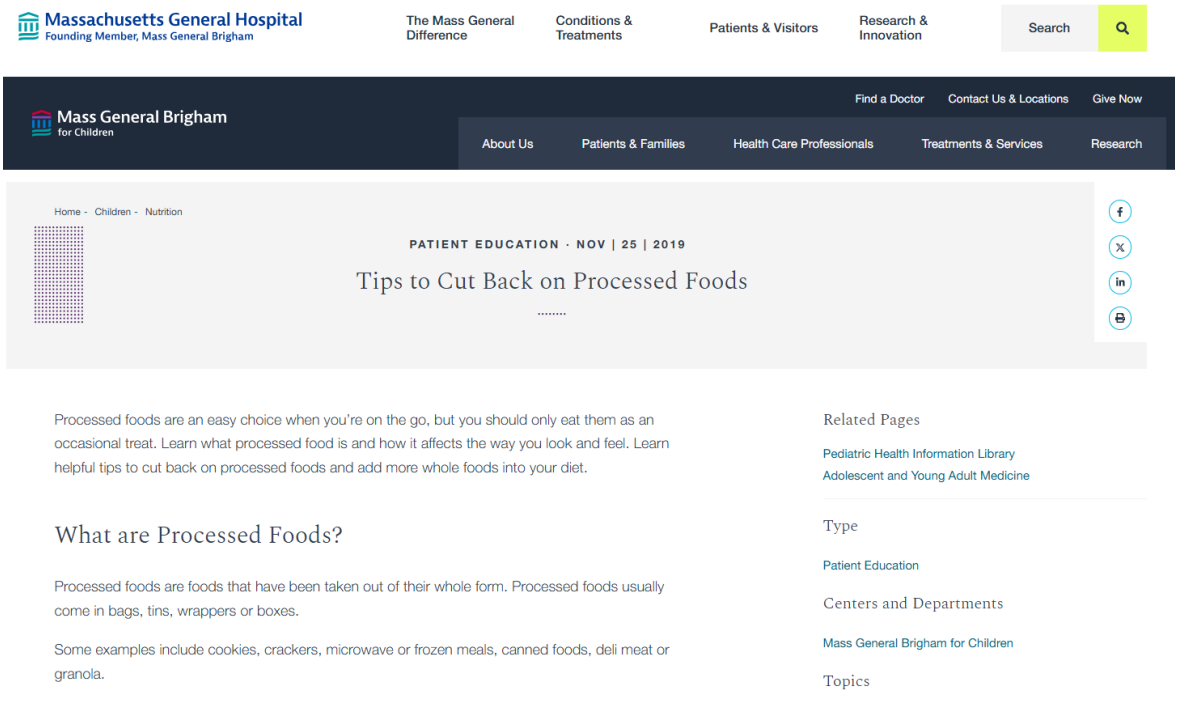


Figure 3 - Patient Education Webpage from the Mayo Clinic[38]

SPEAKING OF HEALTH | THURSDAY, JULY 25, 2024

What you should know about processed, ultra-processed foods

TOPICS IN THIS POST

Nutrition | Get Healthy Recipes And Tips



Processed, and especially ultra-processed, foods have been blamed for the national rise in obesity, high blood pressure and diabetes. But what exactly are these foods, and are they really all that bad for you?

Defining processed foods

According to the Department of Agriculture, processed foods are any raw agricultural commodities altered from their original state. This includes washing, cleaning, milling, cutting, chopping, heating, pasteurizing, blanching, cooking, canning, freezing, drying, dehydrating, mixing or packaging.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-26

Subject: Council on Science and Public Health Sunset Review of 2016 House Policies

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

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

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 (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.

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RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-120.936	Urine Drug Testing	Our AMA will, in conjunction with the AMA Opioid Task Force, develop practical guidance and educational materials to assist physicians with implementing urine drug testing as part of a risk mitigation strategy when opioid analgesics are prescribed for chronic use.	Rescind, accomplished. *The AMA hosted the Webinar "The Art of Urine Drug Testing: A Patient-Centered Approach." The AMA also promotes related education on the AMA Ed Hub™: Fundamentals of Urine Drug Testing and Crossing the Knowledge Gap in Drug Test Interpretation.*
D-120.937	Hormone Therapies: Off-Label Uses and Unapproved Formulations	Our AMA urges the United States Pharmacopeia to re-examine the validity of the current estriol monograph.	Retain, still relevant.
D-120.940	NPS Report Distribution to Practicing Physicians	Our AMA will distribute and promote the National Pain Strategy report to practicing physicians.	Rescind, accomplished.
D-120.969	Compounded Hormone Therapy Preparations	Our AMA: (1) recognizes the term "bioidentical hormone" as a marketing term not grounded in science; use of the term "compounded hormone therapy" is preferred; (2) will urge that renewed attention be devoted to the purity and potency of compounded hormone therapy formulations; (3) will urge continued attention to the reporting of adverse events related to the use of compounded hormone therapies; (4) recommends that physicians and other prescribers fully inform patients of the potential side effects and risks of the use of compounded hormone replacement therapy; (5) will request that when drug ingredients with black box warnings are used in compounded products, patients should be informed about the warnings and precautions associated with the use of such drug ingredients; and (6) supports that patients be informed that compounded products are not FDA-approved.	Retain, still relevant.

D-120.988	Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers	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.	Retain, still relevant.
D-135.970	Coal-Tar Based Sealcoat Threat to Human Health and the Environment	Our AMA will advocate for legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH) or require use of sealcoat products that contain minimal PAH.	Retain, still relevant.
D-135.986	Public Health Hazards Associated with Landscaping Services	Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect & grub control, tree & bush care, debris removal, fence, driveway, rock garden & stone path construction requiring use of saws, and a full spectrum of motorized equipment).	Retain as amended to correct formatting errors. Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect, and ~~&~~ grub control, tree ~~&~~ and bush care, debris removal, fence, driveway, rock garden and ~~&~~ stone path construction requiring use of saws, and a full spectrum of motorized equipment).
D-135.987	Modern Chemicals Policies	Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that	Retain, still relevant.

		requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.	
D-135.993	Contamination of Drinking Water by Pharmaceuticals and Personal Care Products	Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.	Retain as amended and convert to an H-policy. Our AMA supports ~~the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for~~ the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. *The EPA has developed resources and finalized a rule on managing pharmaceutical waste.*
D-30.994	Take Action to End Alcohol Ads on College Sports Telecasts	Our AMA will enhance its efforts to end alcohol advertising on sports broadcasts and particularly on college sports broadcasts; and to reach this goal, work with others to place special emphasis on college athletic conferences that are now or soon will be negotiating broadcast rights contracts, taking steps that include, but are not limited to: (1) Appealing directly to the NCAA, all college athletic conferences and member schools to end alcohol ads on their broadcasts; (2) Encouraging physicians, particularly those in or associated with college communities, to express their	Retain, still relevant.

		opposition to alcohol ads directly to top college administrators; (3) Urging state and local medical associations to contact colleges in their jurisdictions--particularly in the above conferences--and press them to end alcohol ads on their broadcasts; (4) Urging state and local medical associations to call on state legislatures to pass resolutions requesting colleges in their state to end alcohol ads on their broadcasts; and (5) Organizing a "sign-on" letter from medical societies to the NCAA President and Executive Committee urging an end to alcohol ads on NCAA broadcasts.	
D-440.997	Support for Public Health	1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. 2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and	Retain as amended. 1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members~~?~~ and patients in public health-related areas, and the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.

		encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes. 3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.	
D-490.979	Banning Smoking in All Workplaces	Our AMA will (1) actively support national, state, and local legislation and actively pursue regulations banning smoking in all workplaces; and (2) work to ensure that federal legislation banning smoking in all workplaces does not prohibit or weaken more strict state or local regulations.	Retain, still relevant.
D-620.989	Promote Teen Health Week	1. Our AMA will actively promote Teen Health Week 2017 and encourage state medical associations and specialty medical associations across the nation to join the initial efforts as originated in Pennsylvania, and will encourage schools and other appropriate organizations to adopt, promote and participate in Teen Health Week. 2. Our AMA will actively advocate, through direct communication with the appropriate agencies and organizations,	Retain as amended and convert to an H-policy. 1. Our AMA will actively promote Teen Health Week ~~2017~~ and encourage state medical associations, ~~and~~ specialty medical associations, ~~across the nation to join the initial efforts as originated in Pennsylvania, and will encourage~~ schools and other appropriate organizations to adopt, promote and participate in Teen Health Week. ~~2. Our AMA will actively advocate, through direct communication with the~~

		for the development of an annually recognized Teen Health Week.	~~appropriate agencies and organizations, for the development of an annually recognized Teen Health Week~~ *The AMA promoted Teen Health Week via an article in 2017 and 2018. We also promoted the International Adolescent Health Week in 2021 (Facebook interview with founder of IAHW).*
H-10.961	Ocular Injuries from Air Guns	Our AMA: (1) encourages the use and provision of protective eyewear when using air guns; and (2) encourages education on the proper use of protective eyewear to avoid ocular injuries.	Retain, still relevant.
H-10.974	Assurance of the Public's Health Aboard Cruise Ships	The AMA, through federal legislation or international treaty as appropriate, urge the development of standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports.	Retain as amended. The AMA~~, through federal legislation or international treaty as appropriate, urge the development of~~ supports standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports. *The American College of Emergency Physicians published Cruise Ship Health Care Guidelines, which according to the CDC, most major cruise lines follow.*
H-115.985	Warning Labels on Over-The-Counter Iron Preparations and Dietary Supplements	The AMA (1) urges physicians to warn diagnosed patients with hereditary hemochromatosis against the use of over-the-counter iron preparations and dietary supplements containing iron; (2) believes that therapeutic doses of iron should be used only to treat iron-deficiency anemia; and (3) believes that the prophylactic use of iron preparations should be reserved for individuals at high risk of developing iron deficiency.	Retain, still relevant.

H-120.932	Pharmacy Review of First Dose Medication	It is AMA policy that a pharmacist should be available in person or by other means for consultation when medication is administered in a hospital setting.	Retain, still relevant.
H-120.943	Adequate Prescription Medication Supply	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.	Retain, still relevant.
H-120.945	Pharmacy Compounding	Our AMA: (1) recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; (2) encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the	Retain, still relevant.

		standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; (3) supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; (4) supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and (5) in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding.	
H-120.963	Epidemiology of Drug Errors	The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors.	Retain as amended to update terminology and correct spelling. The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacop~~o~~eial Convention, ~~Inc.~~, along with its own ongoing

			initiatives, to identify and eliminate causes of medication errors.
H-125.985	Expanded Use of the AMA's Principles of a Sound Drug Formulary	Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.	Retain as amended. Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System ~~(as described in BOT Rep. 28, I-00)~~ as they develop their pharmaceutical benefit plan(s) ~~and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.~~ *AMA does not have control over this resource and thus, would not showcase it on our website. The resource is readily available online.*
H-130.979	National Disaster Medical System	The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency.	Retain as amended. The AMA endorses the U.S. Administration for Strategic Preparedness and Response's ~~U.S. Department of Homeland Security's~~ National Disaster Medical System which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency. *The National Disaster Medical System is no longer managed under the Department of Homeland Security; it's under HHS's Administration for Strategic Preparedness and Response.*

H-135.924	Assurance and Accountability for EPA's State Level Agencies	Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.	Retain, still relevant.
H-135.925	Medications Return Program	1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications 2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste. 3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.	Retain, still relevant.
H-135.927	Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting	1. Our AMA supports the proper conversion to community-based Light Emitting Diode (LED) lighting, which reduces energy consumption and decreases the use of fossil fuels. 2. Our AMA encourages minimizing and controlling blue-rich environmental lighting by using the lowest emission of blue light possible to reduce glare. 3. Our AMA encourages the use of 3000K or lower lighting for outdoor installations such as roadways. All LED lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods.	Retain, still relevant.
H-135.936	Proper Disposal of Unused Prescription and	1. Our AMA supports initiatives designed to promote and facilitate the	Retain as amended.

	Over-the-Counter (OTC) Drugs	safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.	1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA ~~will work with other~~ supports efforts by national organizations and associations to inform, encourage, ~~support~~ and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA ~~will work with~~ supports other appropriate organizations ~~to~~ developing a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling. *Related AMA work includes the following: Keeping unused meds out of the wrong hands just got easier ; 2024 FDA Guidance ; 2025 FDA Guidance ; AMA 2019 Article – AMA urges participation in Prescription Drug Take Back Day*.
H-135.956	Human and Environmental Health Impacts of Chlorinated Chemicals	The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction	Retain, still relevant.

		practices by the chemical and manufacturing industries.	
H-145.973	Firearm Related Injury and Death: Adopt a Call to Action	Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.	Retain, still relevant.
H-145.982	Prevention of Ocular Injuries from BB and Air Guns	The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.	Retain, still relevant.
H-15.978	Voluntary Highway Lights-On Campaign	The AMA advocates and encourages the institution of voluntary lights-on efforts during daylight hours for all motor vehicles not already automatically equipped with daytime running lights on American highways.	Retain, still relevant.
H-150.979	Fast Food	The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer	Retain as amended to correct grammar. The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer

		low fat alternatives to highly saturated fat foods.	low fat alternatives to foods high~~ly~~ in saturated fat ~~foods~~.
H-170.995	Healthful Lifestyles	The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.	Retain as amended to correct grammar. The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of healthy lifestyles.
H-20.904	HIV/AIDS Education and Training	(1) Public Information and Awareness Campaigns Our AMA: a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection. b) Our AMA urges the communications industry, government officials, and the	Retain as amended to update terminology. …(3) Education and Training Initiatives for Practicing Physicians and Other Health Care ~~Workers~~ Personnel Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health ~~workers~~ personnel (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

		health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection; c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies; d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities; e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve. (2) HIV/AIDS Education in Schools Our AMA: a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission,	

		and recommended risk reduction strategies; b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools. (3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.	
H-215.961	Community Benefit Dollars for Diabetes Prevention	1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program. 2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention	Retain, still relevant.

		Recognition Program with community benefit dollars. 3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients. 4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.	
H-245.967	Prevention of Newborn Falls in Hospitals	Our AMA supports implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches.	Retain, still relevant.
H-25.991	Alzheimer's Disease	Our AMA: (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services; (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; (4) encourages studies to determine how best to provide stable funding for the	Retain, still relevant.

		long-term care of patients with Alzheimer's disease and other dementing disorders; (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations; (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.	
H-280.946	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	Our AMA urges long-term care facilities and other appropriate organizations to: (1) adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and (2) provide staff with in-service training to develop a framework to address intimacy in their patient population.	Retain, still relevant.
H-30.935	Powdered Alcohol	Our AMA supports federal and state laws banning the manufacture, importation, distribution, and sale of	Retain, still relevant.

		powdered or crystalline alcohol intended for human consumption.	
H-30.948	Improving Nutritional State of Persons with Alcohol Use Disorder	The AMA encourages appropriate local, state and federal agencies to increase their efforts to: (a) improve the overall nutritional and health status of individuals with alcohol dependency and (b) reduce alcohol dependency.	Retain as amended to align the policy language with the title. The AMA encourages appropriate local, state and federal agencies to increase their efforts to: (a) improve the overall nutritional and health status of individuals with alcohol use disorder ~~dependency~~ and (b) reduce alcohol use disorder ~~dependency.~~
H-345.971	Faith and Mental Health	Our AMA supports: (1) mental health and faith community partnerships that foster improved education and understanding regarding culturally competent, medically accepted, and scientifically proven methods of care for psychiatric and substance use disorders; (2) better understanding on the part of mental health providers of the role of faith in mental health and addiction recovery for some individuals; and (3) efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services.	Retain, still relevant.
H-345.974	Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities	Our American Medical Association supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets.	Retain, as amended to update language to be more inclusive. Our American Medical Association supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse~~, multi-ethnic~~ communities at ~~greatest~~ risk, and encourages greater cultural and linguistic-competent outreach to ~~ethnic~~ communities including partnerships with ~~ethnic~~ community organizations

H-370.961	Umbilical Cord Blood Transplantation: The Current Scientific Understanding	Our AMA will: (1) encourage continued research into the scientific issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and (2) support education for physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation.	Retain, still relevant.
H-370.970	Umbilical Cord Blood Transplantation: The Current Scientific Understanding	Our AMA: (1) urges physicians to recognize that umbilical cord blood transplantation is a viable alternative to bone marrow transplantation in appropriately selected patients; (2) encourages the development of national standardized guidance to address the ethical, economic, and social issues surrounding umbilical cord blood transplantation; and (3) will continue to study cord blood banking in this country, and work with appropriate specialty societies and organizations, such as the National Marrow Donor Program, to develop and disseminate materials to educate physicians and the public about the issues of marketing cord blood banking services directly to patients, the informed consent process, and the existence of federally mandated regulatory oversight of these processes to ensure safety and compliance with specific uniform standards.	Retain, still relevant.

H-420.982	Standard Terminology for Reporting of Reproductive Health Statistics in the United States	The AMA supports attempts to standardize terminology for reproductive health statistics and, thus, to provide a uniform basis from which the collection and analysis of statistical data may proceed.	Retain, still relevant.
H-425.984	Clinical Preventive Services	Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.	Retain, still relevant.
H-440.824	Educating Clinicians and the Public About Amebic Meningoencephalitis	Our AMA supports: (1) CDC training and education efforts relating to Primary Amebic Meningoencephalitis (PAM); and (2) clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM.	Retain, still relevant. *Diagnosis of PAM is almost exclusively through CDC, which provides 24/7 support. CDC has a page on treatment options. With only 5 survivors and a survival rate of only 5%, it's hard to know what works. Delayed diagnosis is still*

			thought to be a common reason for bad outcomes with PAM.
H-440.825	Fund for Public Health Emergency Response	Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.	Retain, still relevant.
H-440.826	Opposition to Quarantine for Zika Patients	Our AMA opposes quarantine measures for Zika-infected patients.	Retain, still relevant.
H-440.841	Permitting Sunscreen in Schools	1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization. 2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.	Retain, still relevant.
H-440.864	Noise Pollution	Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure.	Retain, still relevant.
H-440.879	Expedited Partner Therapy (Patient-delivered Partner Therapy): An Update	Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its 2006 white paper, Expedited Partner Therapy in the Management of Sexually Transmitted Diseases.	Retain as amended. Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its ~~2006 white paper, Expedited Partner Therapy in the Management of Sexually Transmitted~~

			~~Diseases~~ Sexually Transmitted Infections (STI) Treatment Guidelines.
H-440.880	Definition of Health	The AMA officially adopts the following definition of health: "Health is a state of physical and mental well-being."	Retain, still relevant. *The Council notes that this definition should include social well-being, but the sunset report is not the appropriate mechanism for this change.*
H-440.897	Noise Induced Hearing Loss In Children And Adolescents	1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents. 2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour. 3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL. 4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.	Retain as amended. 1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents. 2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL~~, or greater than 90 dB SPL for more than one hour~~. 3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL~~, or greater than 90 dB SPL~~. 4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss. *According to the National Institute on Deafness and Other Communication Disorder noises are more likely to damage*

			your hearing if they are: 85 dBA and last a few hours; 100 dBA and last at least 14 minutes; or 110 dBA and last at least 2 minutes. 85 dB is the level set by the National Institute of Occupational Health and Safety (NIOSH) for mandatory hearing protection.
H-440.948	Health Care Workers Infected with Hepatitis B Virus	All health care workers (i.e., any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker) who are at risk of infection with HBV should be fully immunized with HBV vaccine.	Retain as amended to update language with a change in title. Health Care ~~Workers~~ Personnel Infected with Hepatitis B Virus All health care personnel ~~workers~~ (i.e., any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker) who are at risk of infection with HBV should be fully immunized with a HBV vaccine.
H-455.986	Radon in Residential Dwellings and other Buildings	Our AMA (1) supports assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in residential dwellings and other buildings and the possible health effects of those levels; and (2) encourages the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.	Retain as amended. Our AMA (1) supports ~~assuming a leadership role in~~ educating physicians, others ~~of~~ in the health care community, and the public concerning the significance of radon levels in residential dwellings and other buildings and the possible health effects of those levels; and (2) encourages the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.
H-455.989	Involvement of Physician Expertise in Non-Military Radiation Emergencies	The AMA encourages physicians to provide expertise on the health aspects of radiation incidents, emergencies and accidents to the public, the media and responsible government agencies.	Retain, still relevant.
H-460.897	Tobacco Use or Exposure as a Variable in Clinical Research	Our AMA urges clinical investigators to carefully consider the need to include an assessment of smoking status, smoking history, and exposure to secondhand smoke in the design of	Retain, still relevant.

		clinical trial protocols and analysis of patient outcomes.	
H-460.929	Expanded Public Education Program in Support of Animal Research	The AMA opposes legislative limits placed on the appropriate and humane use of animals in research.	Retain, still relevant.
H-470.965	Ultimate and Extreme Fighting	Our AMA: (1) opposes ultimate fighting and extreme fighting events; and (2) encourages states which have not banned these events to pass a law doing so.	Retain, still relevant.
H-480.944	Improving Genetic Testing and Counseling Services	Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.	Retain, still relevant.
H-480.945	Genome Editing and its Potential Clinical Use	Our AMA (1) encourages continued research into the therapeutic use of genome editing; and (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.	Retain, still relevant.
H-485.992	Support for Increased Educational	The AMA encourages independent television stations and network affiliates throughout the United States to	Retain, still relevant.

	Children's Television Programming	broadcast at least one hour per day, during regular viewing hours, of educational programming for children.	
H-495.977	Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities	Our AMA supports efforts to ban the sale of tobacco products meeting the definition of "tobacco product" under the Family Smoking Prevention and Tobacco Control Act, with the exception of medicinal nicotine products approved by the FDA, where health care is delivered or where prescriptions are filled, including retail outlets housing store-based health clinics.	Retain, still relevant.
H-50.972	Blood Donor Deferral Criteria Revisions	Our AMA will advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for individual risk assessment during the public commentary period.	Rescind. *Current AMA policy "Blood and Tissue Donor Deferral Criteria H-50.973" is more comprehensive.*
H-505.961	Challenging the Pro-Tobacco Actions of the U.S. Chamber of Commerce	1. Our AMA strongly objects to any pro-tobacco efforts by the U.S. Chamber of Commerce and encourages the U.S. Chamber of Commerce to be transparent in all advocacy activity on behalf of tobacco companies. 2. Our AMA urges conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization.	Retain, still relevant. *The original policy was prompted by a multipart NYT investigation into how the U.S. Chamber of Commerce (U.S. Chamber) has helped the tobacco industry fight life-saving policies in more than a dozen countries.*
H-510.988	Supporting Awareness of Stress Disorders in Military Members and Their Families	Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of	Retain, still relevant.

		Defense and the Department of Veterans Affairs.	
H-525.975	Heart Disease in Women	1. Our AMA supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women. 2. Our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.	Retain, still relevant.
H-525.976	An Expanded Definition of Women's Health	Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.	Retain as amended to address formatting error. Our AMA recognizes the term "women's health" ~~—~~as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.
H-525.991	Inclusion of Women in Clinical Trials	Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages	Retain, still relevant.

		translation of important research results into practice.	
H-60.916	Youth Incarceration in Adult Facilities	1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records. 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.	Retain as amended. 1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any ~~criminal justice~~ correctional facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records. 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult ~~criminal justice~~ correctional facilities. *The term "criminal justice facility" is not commonly used, especially by NCCHC. The appropriate term is "correctional facility." Amendments reflect that change.*
H-60.922	Solitary Confinement of Juveniles in Legal Custody	Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.	Retain as amended to update language and change in title. Title Change: Solitary Confinement of Juveniles in ~~Legal Custody~~ Correctional Facilities Our AMA: (1) opposes the use of solitary confinement in juvenile correctional facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
H-60.930	Insufficient Sleep in Adolescents	1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a	Retain, still relevant.

		standard component of care for adolescent patients. 2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.	
H-60.986	Health Status of Detained and Incarcerated Youth	Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care; (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children	Retain as amended to update language. (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental health conditions ~~illness~~; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

		and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior. (3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided. (4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.	
H-65.974	Gender-Based Violence	Our AMA: (1) opposes inhumane treatment of people of both genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof.	Retain as amended to update language. Our AMA: (1) opposes inhumane treatment of people of ~~both~~ all genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for ~~victims~~ survivors thereof.
H-75.987	Reducing Unintended Pregnancy	Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the	Retain as amended to update language. Our AMA: (1) urges health care professionals to provide care for ~~women~~ patients of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process;

		training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.	
H-75.996	Media Advertising and Public Service Announcements Regarding Contraception and Safe Sexual Practices	The AMA urges the print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness.	Retain, still relevant.
H-90.967	Support for Persons with Intellectual Disabilities	Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.	Retain, still relevant.
H-95.933	Action to Address Illegal Methamphetamine Production	Our AMA supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine abuse.	Retain as amended to update language. Our AMA supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine misuse and use disorder. ~~abuse~~
H-95.935	Increasing Awareness of Nootropic Use	1. Our AMA: (a) opposes the prescription of controlled substances, including stimulants and wakefulness-promoting agents, for the purpose of cognitive enhancement in otherwise normal, healthy individuals; and (b) discourages the nonmedical use of	Retain, still relevant.

		prescription drugs, including stimulants and wakefulness-promoting agents for cognitive enhancement at all levels of education and in the workplace. 2. Our AMA encourages continued research into the risks and benefits of drugs and other substances for improving function in patients undergoing cognitive decline or who are experiencing cognitive impairment. 3. Our AMA encourages more research into the patterns of use, as well as risks and benefits, of dietary supplements (including herbal remedies) being promoted for cognitive enhancement. 4. Our AMA urges the Federal Trade Commission to examine advertisements for dietary supplements and herbal remedies that claim cognitive enhancement to ensure that they are truthful and not misleading, and are substantiated.	
H-95.942	Safe Disposal of Used Syringes, Needles and Other Sharps in the Community	1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. 2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. 3. Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal.	Retain as amended. 1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. 2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. 3. Our AMA continues to support the mission of SafeNeedleDisposal.org ~~the Coalition for Safe Community Needle Disposal~~. *The Coalition was renamed in 2014 in accordance with new ownership.*

H-95.958	Syringe and Needle Exchange Programs	Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.	Retain as amended to update language. Our AMA: (1) encourages all communities to establish ~~needle~~ syringe exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for ~~needle~~ syringe exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that people who inject drugs ~~injection drug users~~ can purchase and possess needles and syringes without a prescription and ~~needle~~ syringe exchange program employees are protected from prosecution for disseminating syringes.

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Setting Standards for Forensic Toxicology Laboratories Used in Litigation

EXECUTIVE SUMMARY

BACKGROUND. Resolution 212-A-25, referred by the House of Delegates (HOD), asked our American Medical Association (AMA) to pursue legislative or regulatory changes to require: 1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; 2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; 3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; 4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “CLIA-exempt toxicology labs”, “forensic labs”, “toxicology labs” AND “litigation”, and “forensic labs AND crime”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and other applicable organizations were also reviewed for relevant information.

DISCUSSION. Forensic toxicology laboratories play a critical role in medicolegal decision-making, yet unlike CLIA-regulated clinical laboratories, CLIA-exempt forensic labs operate without a unified national oversight system, resulting in fragmented standards, inconsistent accreditation practices, and limited transparency. National scientific reviews have repeatedly documented deficiencies in method validation, quality assurance, independence, and access to underlying laboratory data, as well as instances of laboratory fraud and misconduct.

CONCLUSION. This report reviews the current oversight structure for forensic toxicology laboratories, outlines key differences between clinical and forensic laboratory regulation, and summarizes the extensive scientific literature documenting persistent challenges—such as inconsistent standards, insufficient method validation, limited access to underlying laboratory data, cognitive bias, and cases of laboratory fraud. It further examines the economic and operational pressures facing laboratories and the uneven adoption of accreditation and quality systems. Based on these findings, the recommendations support the development of consistent national baseline standards, a coordinated accreditation framework, increased transparency in laboratory practices, and nationally aligned expectations for scientific qualifications and oversight in CLIA-exempt forensic toxicology laboratories.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-26

Subject: Setting Standards for Forensic Toxicology Laboratories Used in Litigation

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 212-A-25, "Setting Standards for Forensic Toxicology Laboratories Used in Litigation," was referred by the House of Delegates (HOD), and asked the following:

That our American Medical Association pursue legislative or regulatory changes to require:

1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; and
2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; and
3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; and
4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and
5. that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results.

BACKGROUND

In the United States (U.S.), the type of laboratory accreditation required by a toxicology laboratory depends on the purpose of the laboratory's testing menu: clinical versus forensic. Like all clinical laboratories, clinical toxicology laboratories are subject to direct federal regulatory requirements for Clinical Laboratory Improvement Amendments of 1988 (CLIA) certification, classified as waived, moderate, or high-complexity testing operations.[1] CLIA requirements include on-site inspections and acceptable participation in proficiency testing, which may be met by achieving accreditation from an agency with CLIA-deemed status.[2,3] Forensic toxicology laboratories are CLIA-exempt under federal regulations but nonetheless subject to all applicable state and local regulatory requirements, which typically mandate independent laboratory accreditation.[4] Forensic science performed in toxicology labs has faced increasing scrutiny regarding these labs' methods and reliability.[5,6]

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A multi-year, Congressionally-mandated study released in 2009 by the National Research Council (NRC) was critical of weaknesses in the scientific underpinnings of the forensic disciplines routinely used in the criminal justice system.[6] The NRC outlined a comprehensive series of recommended reforms (see Table 2).[6] Reports have also highlighted concerns regarding the lack of standardization and oversight, the absence of independence of forensic laboratories from law enforcement, bias affecting the results and their interpretation, and the lack of reporting on measurement uncertainty.[6,7] In addition to calls for improvements in forensic science methods, there have been prominent cases of fraud by forensic scientists.[5,8] While toxicology is often perceived as one of the more objective forensic disciplines due to its reliance on analytical chemistry and quantitative measurements, it is not immune to bias, fraud, and error.[5,8,9] However, it is important to note that forensic toxicology laboratories face mounting pressures—including rising case volumes, staffing shortages, limited funding, and expanding testing demands—that contribute to persistent backlogs and hinder their capacity to maintain rigorous scientific practices.[6] These strains are intensified by the need to triage urgent requests, outdated equipment in some jurisdictions, and limited federal investment in toxicology research, leaving many labs without the resources needed for method validation, quality assurance, or modernization.[6]

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “CLIA-exempt toxicology labs”, “forensic labs”, “toxicology labs” AND “litigation”, and “forensic labs AND crime”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and other applicable organizations were also reviewed for relevant information.

DISCUSSION

For the purposes of this report, forensic science refers to the application of scientific or technical practices to the recognition, collection, analysis, and interpretation of evidence for criminal, civil, or regulatory matters.[9] It encompasses a wide range of disciplines with distinct technologies and practices.[9] The National Institute of Justice (NIJ) categorizes these into multiple areas, including toxicology, firearms and toolmarks, questioned documents, trace evidence, controlled substances, DNA and serology screening, fire debris analysis, post-mortem analysis, impression and blood-pattern evidence, crime-scene investigation, medicolegal death investigation, and digital evidence.[10]

Because these disciplines vary widely in methods, error rates, research foundations, and levels of scientific acceptance, forensic science is not a uniform field.[6,7] Some areas rely on laboratory-based analytical techniques (i.e., DNA analysis, toxicology, drug chemistry), while others depend heavily on expert interpretation of observed patterns (i.e., fingerprints, handwriting, toolmarks, bite marks).[7,11] Forensic work is performed by individuals with diverse training backgrounds—from scientists such as chemists and biologists to law-enforcement personnel, crime-scene specialists, forensic pathologists, and laboratory technologists.[12] Importantly, Many forensic techniques are based on practical experience rather than fully validated scientific methods, and therefore may not fully account for the limitations inherent in their underlying methodologies.[6,7]

Forensic science has transformed litigation by introducing objective, empirically grounded evidence that helps courts resolve complex questions with far greater accuracy and confidence.[9] Advances such as DNA analysis have exonerated the innocent and identified perpetrators with unprecedented precision, fundamentally improving fairness and reliability in the justice system.[9] Across disciplines—including toxicology, digital forensics, and pattern evidence—scientific

methods now provide critical insights that strengthen fact-finding, support informed judicial decision-making, and enhance public trust in legal outcomes.[6,9]

What is the difference between clinical and forensic toxicology laboratories?

Both clinical and forensic toxicology laboratories aim to deliver accurate and timely analytical results, but they differ in purpose, end-users, and operational requirements.[13] Clinical laboratories perform rapid physiological testing to guide patient care, while forensic laboratories conduct one-time analyses intended for medicolegal proceedings.[6,14] Consequently, the two types of laboratories differ in how samples are collected and processed, the staffing and funding structures they rely on, and the technologies they employ.[6,14]

All U.S. clinical laboratories are regulated under CLIA, which applies to any facility performing tests on human specimens for diagnosis, treatment, prevention, or health assessment.[1,6,15] CLIA requires certification, biennial inspections, proficiency testing, quality control and quality assurance procedures.[6,15] Enforcement mechanisms include sanctions, certificate suspension or revocation, civil injunctions, fines, and publication of laboratory sanctions. Clinical labs must meet these standards to receive Medicare or Medicaid reimbursement.[1,6,15]

In contrast, toxicology laboratories performing only forensic testing are CLIA-exempt, because they test human specimens for purposes other than medical diagnosis or treatment—such as criminal, civil, workplace, or other medicolegal uses.[6,14] This category includes Substance Abuse and Mental Health Services Administration (SAMHSA)-certified workplace drug-testing laboratories.[16] Since CLIA does not apply, federal accreditation requirements do not govern these forensic laboratories.[16]

Clinical laboratory toxicology testing may still generate evidence with legal consequences, for example, in cases involving pregnant patients, newborns, children, or individuals involved in injury-producing incidents.[17] Unless requested by law enforcement or a court, such testing is treated as medical rather than forensic. Some clinical laboratories also conduct forensic drug testing, and in these circumstances, they are advised to maintain clear policies that separate clinical and forensic workflows, including specimen handling, processing, and documentation, to ensure appropriate regulatory compliance and evidentiary integrity.[17]

OVERSIGHT OF FORENSIC TOXICOLOGY LABS

Federal and State Oversight

Currently, there is no comprehensive federal regulatory system that oversees or governs forensic toxicology laboratories in the U.S.[18] Oversight is fragmented, largely voluntary, and dominated by private accreditation bodies, not federal regulation.[6,18] The only significant federal accreditation requirement applies to DNA labs participating in the Combined DNA Index System , via the DNA Identification Act.[19] Some federal entities operate forensic toxicology laboratories, but these labs follow internal standards and do not regulate state or local forensic toxicology labs.[20] As a result, voluntary accreditation is the closest thing to oversight of forensic toxicology labs.[21]

Given the lack of federal oversight, some states have established oversight bodies, including state forensic science commissions, task forces, oversight and advisory boards, or investigative councils with the goal of improving the field of forensic sciences through oversight and coordination of forensic science resources.[22] Twenty-one states and Washington, D.C. currently have statutorily

created or created by another means, such as through state legislation, forensic science state commissions or oversight bodies; however, all vary considerably with respect to which functions they fulfill (See Figure 1).[22]

Accreditation

Accreditation of toxicology laboratories relies on a multilayered system built around internationally recognized technical standards—primarily International Organization for Standardization (ISO) and the International Electrotechnical Commission (IEC) 17025—supported by national accrediting bodies and supplemented by state requirements that add discipline-specific controls.[23] These mechanisms aim to ensure that laboratories produce scientifically valid, reliable, and defensible results for criminal justice, medicolegal death investigation, and public safety.[23] Accreditation involves external experts who review documentation, perform on-site assessments, evaluate corrective actions, and verify ongoing compliance through surveillance audits.[23]

Two major accrediting bodies— ANSI National Accreditation Board (ANAB) and American Association for Laboratory Accreditation (A2LA)—currently accredit most forensic laboratories.[24,25] ANAB, which absorbed the former American Society of Crime Laboratory Directors (ASCLD/LAB), accredits labs to ISO/IEC 17025 and is the sole accreditor approved by several state forensic commissions.[26] It also evaluates laboratories using the American Board of Forensic Toxicology (ABFT) toxicology checklist, providing dual recognition for ISO/IEC 17025 with toxicology-specific criteria.[24,27] A2LA accredits laboratories under ISO/IEC 17025 for testing and calibration and ISO/IEC 17020 for inspection functions.[25] The College of American Pathologists (CAP), while best known for clinical laboratory accreditation, accredits clinical-toxicology laboratories and those operating in hybrid forensic-clinical environments.[28] It should be noted that there are various players involved in forensic toxicology laboratory practice that include laboratory accrediting bodies, standards-setting groups, professional societies, and oversight organizations (see Table 1).

However, accreditation is not guaranteed of error-free performance. Recent events continue to illustrate that accreditation alone does not consistently prevent fraud, deter misconduct, or ensure reliable scientific practices.[6–8] For example, an Injustice Watch investigation found that the accredited University of Illinois Chicago Analytical Forensic Testing Laboratory produced flawed and misleading THC test results used in cannabis DUI prosecutions across the state, with evidence that methodological problems were concealed for years despite accreditation audits.[6–8] This suggests that confidence in accredited labs may at times be misplaced. Because accreditation is not universally required, many unaccredited forensic laboratories continue operating without any substantial external oversight.

BRIEF SUMMARY OF ISSUES IN FORENSIC SCIENCE IN COURT PROCEEDINGS

Courts act as gatekeepers to ensure expert testimony is based on reliable science.[29,30] In practice, however, many courts admitted forensic toxicology and other forensic results with minimal scrutiny for decades.[5–7,31,32] Appellate analyses have found that judges are often more exacting with expert evidence in civil cases than in criminal cases.[6,33–37] Reports observed this disparity as well, noting appellate courts were "more willing to second-guess…scientific evidence in civil cases than in criminal cases."[6,33–38]

Relatedly, courts historically allowed certain forensic techniques to be presented by experts despite a lack of robust scientific validation.[6,39–41] Prior to the reforms of the last decade, it was not uncommon for a forensic toxicologist to testify about novel or less standard analyses (for instance,

using a new lab-derived method to identify a toxin) without the judge requiring proof of validation.[5–7,42] The consequence, as reports have reiterated, is that some evidence may not have met modern scientific standards of reliability.[6,41,43]

Validation and Research. Multiple studies have repeatedly found that many forensic disciplines rely on tradition and professional judgment rather than rigorous scientific testing.[5–7,40] Two concepts are central to evaluating reliability: foundational validity (whether a method has been empirically shown to work) and validity as applied (whether it was correctly used in a specific case).[7,44,45] Even scientifically sound methods can produce unreliable results without proper validation, consistent application, and clear documentation.[7,40,45,46] Forensic toxicology often uses instruments designed for clinical or research settings, but forensic samples may involve low drug concentrations, degraded materials, or complex mixtures.[7,40,45] Studies emphasize the need for validation that demonstrates repeatability, interlaboratory reproducibility, and known error rates.[6,7,40,45]

Practice Protocols and Standards. The lack of uniform standards across laboratories leads to differing protocols and inconsistent results.[6,31,32] A 2024 National Institute of Standards and Technology (NIST) analysis found that procedures "vary both within and across disciplines," producing variable outcomes that directly affect litigation.[31] For example, one lab may report a substance as present while another—using different thresholds or extraction methods—reports it as negative.[6,7,31] Such inconsistencies can result in different legal outcomes across jurisdictions and contribute to conflicting expert testimony.[6,7,31]

Substances and Technological Gaps. Toxicology laboratories struggle to keep pace with rapidly evolving drug markets, including synthetic opioids, novel psychoactive substances, and adulterants like xylazine.[7,31,47] These trends create significant measurement challenges and often outstrip laboratory method development.[31,47,48] As a result, some substances may go undetected or be mis-quantified, weakening evidentiary reliability in both criminal and civil cases.[7,47,48] Courts require toxicology findings to be valid, reliable, and consistent—standards difficult to achieve without ongoing scientific investment.[7,31,47,49]

Quality Assurance (QA) Programs. Strong quality assurance systems are essential, yet multiple investigations have found serious QA failures in forensic labs.[6,7,50] For example, an audit of the Houston Police Department Crime Lab revealed missing QA programs, insufficient training, poor documentation, analytical errors, and even falsified results.[51–53] Weak QA increases the risk of false positives, false negatives, and contamination, contributing to wrongful convictions; nearly one-quarter of DNA exonerations have involved misapplied forensic science.[6,52–54]

Exculpatory or Contradictory Result Disclosures. Some laboratories have withheld results inconsistent with prosecution theories. For example, a review of the North Carolina State Bureau of Investigation lab found analysts repeatedly omitted confirmatory tests that negated preliminary findings, violating discovery obligations.[7,55] Such nondisclosure can lead to wrongful convictions and undermines the expectation that forensic scientists serve as neutral, objective experts. [7,55–57]

Access to Underlying Data. Even without misconduct, defense teams may struggle to obtain raw data, quality control (QC) logs, or validation records due to proprietary software or restrictive policies.[6,7,58,59] Limited transparency hinders meaningful review of forensic evidence and can mask systemic issues until discovered through litigation or external audits—often years later.[6,7,60]

Cognitive and Contextual Bias. Toxicologists, like other experts, are vulnerable to biases influenced by case context or institutional pressures.[6,61,62] Bias can affect interpretation of marginal

results or QC anomalies.[63,64] Reports have warned of insufficient safeguards against cognitive bias, and few toxicology processes undergo black-box studies to measure examiner error and reliability.[6,7,65,66] These vulnerabilities risk introducing subjectivity into evidence presented as objective.

Overstatement and Over-Interpretation. Experts have historically overstated certainty, implying zero error or drawing unsupported conclusions.[7,67,68] Multiple reports have criticized such overstatement and emphasized that testimony must reflect actual scientific limitations.[6,7,67–69] In toxicology, this includes overstating impairment based on drug levels or failing to provide error rates and probabilities when reporting results.[6,7,67–69] Over-interpretation can mislead courts and juries, compromising fair outcomes.

SYSTEMIC PRESSURES IMPACTING FORENSIC TOXICOLOGY LABS

Forensic toxicology laboratories operate in a system burdened by compounding pressures and economic challenges including persistent backlogs driven by rising case submissions, limited staffing, inadequate funding, and expanding statutory testing requirements.[6,70,71] Studies show that forensic toxicology laboratories routinely process thousands of cases annually, with roughly 20 percent remaining backlogged delays that can prolong incarceration. [6,70,71] As a result, even highly skilled laboratories struggle to keep pace with scientific, operational, and legal expectations, despite their commitment to producing accurate and reliable results.

Law enforcement and prosecutors increasingly demand rapid laboratory results, often before charges are filed and again before trial.[70] At the same time, agencies continue expanding testing requests (i.e., DNA from guns or property crimes), forcing laboratories to triage between urgent new cases and older cold cases, exacerbating workflow bottlenecks.[6,70] DNA analysis—supported by extensive research, strong quality control, and validated statistical models—has become a benchmark for forensic reliability.[6,70,72] Its success highlights the comparative scientific gaps in other disciplines, including toxicology, which receive far less federal investment despite representing the majority of forensic casework.[6,70]

As a result, most forensic disciplines operate with limited research infrastructure, few funding sources, and foundational studies conducted largely within crime laboratories rather than independent academic institutions.[6,7,31,73] This shortage of high-quality research hinders method validation, new tool development, and evidence-based improvements, intensifying pressures on laboratories already operating under substantial resource constraints.[6,7,31,74] Further, accreditation, proficiency testing, and quality assurance programs—while essential to reliability—also impose meaningful financial burdens.[6,74] It should be noted that forensic toxicology labs are not fully supported by a single stable funding system. Instead, they rely on a patchwork of funding sources through a combination of state, county, and municipal appropriations, supplemented by federal grants and fee-for-service revenue for testing performed for law enforcement, courts, medical examiners, and other agencies.[74]

KEY FEDERAL ACTIONS TAKEN TO IMPROVE FORENSIC SCIENCE

Multiple reports have identified systemic deficiencies across forensic science, including fragmented laboratory systems, inconsistent training, limited research funding, and a lack of scientific validation for many commonly used methods.[6,7,31] Recommendations from those reports called for sustained national reform to improve scientific foundations, oversight, and practitioner standards (see Table 2-4).[6,7,31] In response, many national reforms were initiated.[7] These reforms are summarized in Table 4. Collectively, these efforts—national coordination initiatives, standards

development, expanded research funding, and accreditation and certification reforms—represent the most significant progress in the last decade.[75–82] Nonetheless, substantial work remains, particularly in establishing the scientific validity and reliability of many forensic methods still used in courts today.[81]

EXISTING AMA POLICY

The AMA has limited policy on the use of forensic toxicology tests in litigation. AMA Policy H-80.994, "Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System" states that the AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system. However, AMA does have policy regarding CLIA-certified labs. For example, AMA Policy H-480.933, "Regulation and Control of Self-Service Labs" states that the AMA will advocate for direct access testing, in which patients may order a diagnostic laboratory test on demand, should only be provided by teams which are physician-led, and performed in facilities that are CLIA-certified. Finally, the Code of Medical Ethics 4.1.4 "Forensic Genetics" states that physicians from whom genetic information is sought for purposes of criminal justice: may ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient's authorized surrogate) in response to a warrant or court order; should release only the minimum information necessary for the specific purpose; and should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.

CONCLUSION

Forensic toxicology laboratories play a critical role in both civil and criminal litigation, yet the U.S. lacks a unified regulatory framework to ensure their scientific reliability, transparency, and independence.[6,7,79,83] The current system functions largely on voluntary accreditation, variable state oversight, inconsistent methodological standards, and divergent admissibility practices. Although clinical laboratories operate within a comprehensive federal regulatory structure under CLIA, forensic toxicology laboratories remain largely exempt from these requirements.[1,6] This regulatory gap persists despite the scientific complexity and high-stakes consequences associated with toxicology findings in medicolegal settings.[1]

National reviews of forensic science over the past two decades consistently identify the same systemic deficiencies: lack of foundational validation, inadequate quality control systems, limited research infrastructure, vulnerability to cognitive and contextual bias, and insufficient transparency regarding laboratory practices and error rates.[6,7,31,79] Toxicology, though often perceived as an objective, instrument-driven discipline, is not exempt from these shortcomings—particularly when analytical limitations and interpretive errors intersect with the demands of litigation.[5,8] However, forensic toxicology laboratories face mounting pressures—including rising case volumes, staffing shortages, limited funding, and expanding testing demands—that contribute to persistent backlogs and hinder their capacity to maintain rigorous scientific practices.[6] As a result, even highly skilled laboratories struggle to keep pace with scientific, operational, and legal expectations, despite their commitment to producing accurate and reliable results.[6]

This report also highlights the ongoing consequences of fragmentation in forensic laboratory oversight. Inconsistent standards across jurisdictions, gaps in accreditation, and limited access to underlying laboratory data hinder courts' ability to evaluate evidence under modern scientific admissibility standards.[6,7,84] High-profile laboratory fraud cases further underscore the dangers of inadequate auditing, insufficient documentation practices, and the absence of independent oversight.[8,51,52] At the same time, toxicology laboratories face increasing workloads, rapid

proliferation of synthetic and emerging drugs, outdated instrumentation in some jurisdictions, and pressure to produce rapid results—all of which strain their capacity to maintain rigorous scientific practices.[6,70,71] Reports note that the pathway forward must therefore prioritize the core principles of scientific validity, transparency, and accountability.[6,7,31,81] They conclude that by embracing validated methods, standardized practices, and transparent quality systems, forensic toxicology laboratories can better fulfill their essential role in promoting justice, safeguarding due process, and upholding public confidence in the medicolegal system.[6,7,31,81]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 212-A-25, and the remainder of the report be filed.

1. Our American Medical Association supports national efforts to establish a unified, science-based oversight framework for CLIA-exempt forensic toxicology laboratories, including the development of consistent baseline standards, a coordinated national accreditation structure, enhanced transparency requirements, and complementary oversight expectations for individual forensic toxicology practitioners to address the absence of mandatory accreditation and the current fragmentation of quality systems; and

2. Our American Medical Association encourages greater transparency in forensic toxicology laboratory operations, including publicly accessible information on personnel qualifications, accreditation status and scope, quality assurance practices, method validation documentation, and scientific oversight processes, and the key evidentiary materials needed for judicial evaluation such as raw data, validation records, quality-control logs, and proficiency testing results, to strengthen the reliability, interpretability, and accountability of medicolegal testing. (New HOD Policy)

Fiscal Note: Modest

Figure 1: Map of Forensic Science State Commissions or Oversight Bodies.[22]
States with a Commission include Texas, Oklahoma, Missouri, Illinois (also on the Task Force), Indiana, New York, Rhode Island, and Delaware. States with an Advisory/Oversight Board include Montana, Nebraska, Kansas, Arkansas, Alabama, North Carolina, South Carolina, and Massachusetts. States with a committee include Maryland, Wisconsin, and Arizona. States with a Council include Washington State and Washington, DC. States with a Task Force include Michigan. All other states have no commission.

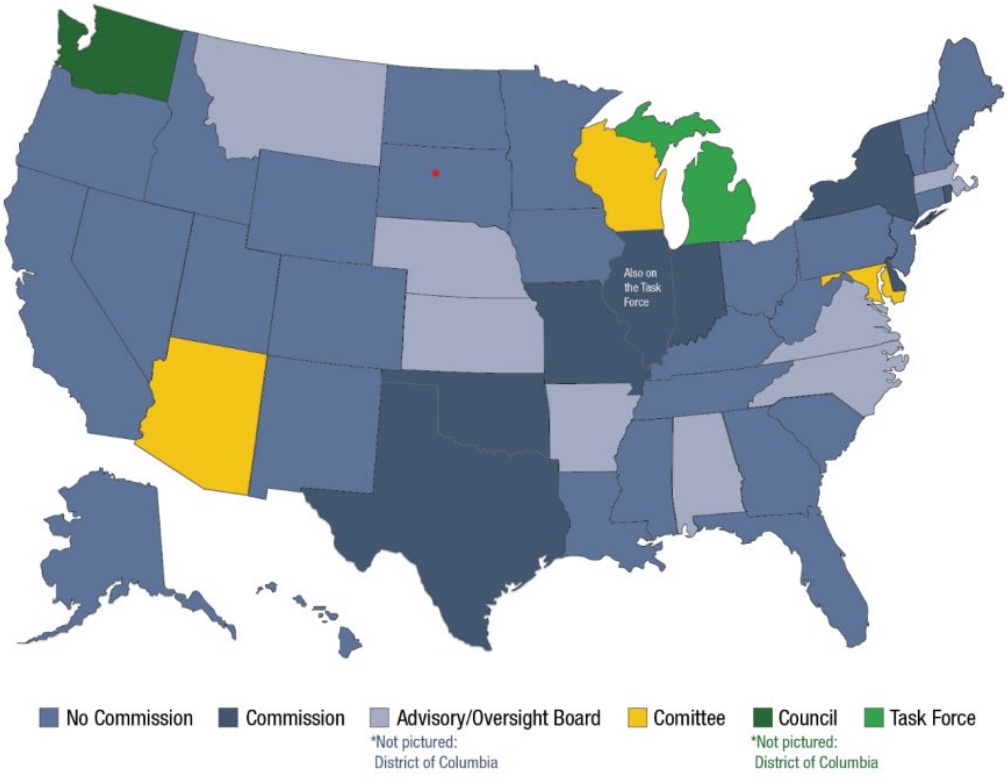


Table 1: Overview of Organizations Involved in Forensic Toxicology Practice and Oversight

Organization	Type	Primary Role in Forensic Toxicology Labs
ANSI National Accreditation Board (ANAB)[26]	Accrediting Body	Accredits forensic laboratories (including toxicology) to ISO/IEC 17025; often integrates ABFT toxicology criteria into scopes.
American Association for Laboratory Accreditation (A2LA)[25]	Accrediting Body	Accredits labs to ISO/IEC 17025 (testing/calibration) and, where applicable, ISO/IEC 17020 (inspection functions).
American Board of Forensic Toxicology (ABFT)[27]	Accrediting Body (Toxicology-Specific) & Individual Certifier	offers laboratory accreditation specifically for forensic toxicology and certification for individual forensic toxicologists.
College of American Pathologists – Forensic Drug Testing (CAP-FDT)[28]	Accrediting Body (Clinical/Forensic Workplace)	Accredits laboratories performing forensic drug testing (often workplace/model programs) and hospital/hybrid settings.
SAMHSA – National Laboratory Certification Program (NLCP)[16]	Federal Certification Program (Workplace Testing)	Certifies laboratories for federal workplace drug testing (urine/oral fluid) under NLCP.
Organization of Scientific Area Committees for Forensic Science (OSAC, NIST)[78]	Standards Development	Develops and promotes science-based forensic standards and posts them to the OSAC registry; informs what accrediting bodies/labs can adopt.
American Society of Crime Laboratory Directors (ASCLD)[26]	Professional Association	Supports lab leadership, quality improvement, and policy; networking/training for lab directors.
American Academy of Forensic Sciences (AAFS)[85]	Professional Society	Multidisciplinary professional home; advances ethics, education, and scientific exchange across forensic disciplines.
Society of Forensic Toxicologists (SOFT)[86]	Professional Society	Discipline-specific community for forensic toxicology; issues practice guidelines, supports training and research.
Consortium of Forensic Science Organizations (CFSO)[87]	Advocacy/Coordination	Represents multiple forensic organizations; advocates for funding, research, and policy reforms.
National Association of Medical Examiners (NAME)[88]	Office Accreditation (Medical Examiner/Coroner)	Accredits medicolegal death investigation offices and sets practice guidelines for me/coroner systems.
International Association of Coroners and Medical Examiners (IACME)[89]	Office Accreditation (Medical Examiner/Coroner)	Accredits coroner/medical examiners' offices; promotes standards for medicolegal death investigation operations.

Table 2: Summary of 13 recommendations made in the 2009 National Research Council report "Strengthening Forensic Science in the United States: A Path Forward.[6]

#	NRC Recommendation	Summary
1	**Create a National Institute of Forensic Science (NIFS)**	Establish an independent federal entity to lead standardization, research, accreditation, and policy.
2	**Standardize terminology and reporting**	Require consistent language, limits statements of certainty, and prevent overstated claims.
3	**Fund research to establish scientific foundations**	Support foundational and applied research in all forensic disciplines, particularly those lacking empirical validation.
4	**Develop and enforce standards for forensic practice**	Create mandatory, science-based standards for methods, training, reporting, and testimony.
5	**Require mandatory accreditation of laboratories**	All forensic laboratories must be accredited and demonstrate adherence to national quality standards.
6	**Require certification of forensic practitioners**	Practitioners should meet competency standards and undergo regular proficiency testing.
7	**Support independence of forensic laboratories**	Remove forensic labs from law-enforcement control to prevent bias and ensure neutrality.
8	**Strengthen quality assurance and quality control**	Implement rigorous QA/QC measures, including blind proficiency testing, to detect errors and misconduct.
9	**Improve forensic science education**	Develop standardized, science-based curricula for universities and training programs.
10	**Create national code of ethics**	Require ethical standards, reporting obligations, and consequences for misconduct or nondisclosure.
11	**Improve medicolegal death investigation systems**	Modernize and professionalize coroner/medical examiner systems nationwide.
12	**Strengthen interoperability and information sharing**	Coordinate forensic data standards and technology across agencies for improved nationwide use.

13	**Increase federal support for forensic science**	Substantially increase sustained funding for research, standards development, and laboratory improvement.

Table 3: Summary of 8 recommendations made in the 2016 Report to the President "Forensic Science in Criminal Courts: Ensuring Scientific Validity."[7]

#	PCAST Recommendation	Summary
1	**Establish clear scientific criteria for "foundational validity"**	Define standards requiring empirical testing, reproducible results, known error rates, and peer-reviewed studies before a forensic method is deemed scientifically valid.
2	**Require empirical "black-box" studies for subjective methods**	Subjective feature-comparison disciplines (e.g., firearms, footwear, bite marks, hair microscopy) must demonstrate accuracy and reliability through properly designed, large-scale black-box studies.
3	**Require empirical testing of "validity as applied"**	Examiners must demonstrate they can reliably apply validated methods in casework through proficiency testing that simulates real forensic conditions.
4	**DOJ/NIST should ensure foundational validity before admitting forensic methods in court**	Federal agencies should evaluate forensic disciplines and clearly identify which methods meet scientific standards for validity. Methods lacking foundational validity should not be presented as reliable evidence.
5	**Develop and fund large-scale independent research programs**	Calls for substantial federal funding (NIJ, NIST, NSF) for foundational and applied research, especially for subjective pattern-comparison methods.
6	**Create national scientific oversight for forensic methods**	Establish bodies (independent of law enforcement) responsible for scientific review, research priorities, and setting validity standards for forensic techniques.
7	**Ensure forensic testimony is scientifically accurate and limited in scope**	Examiners must not overstate conclusions. Testimony should reflect actual empirical support, known error rates, and limitations, avoiding claims of individualization unless scientifically justified.
8	**Strengthen proficiency testing, certification, and accreditation**	Improve examiner certification and lab accreditation by requiring rigorous, scientifically meaningful proficiency tests and transparent reporting of results.

Table 4: Summary of 4 recommendations made in the 2024 National Institute of Standards and Technology report "Strategic Opportunities to Advance Forensic Science in the United States A Path Forward Through Research and Standards."[31]

#	NIST Recommendation	Summary
1	**Accuracy & Reliability of Forensic Methods**	Quantify and establish statistically rigorous measures of accuracy, repeatability, reproducibility, and uncertainty for complex forensic methods
2	**New Methods & Technology Development**	Develop new and improved methods for rapid, robust, and scientifically validated analysis of complex forensic evidence
3	**Science Based Standards & Guidelines**	Develop rigorous, consensus-based documentary standards, conformity assessment schemes, and guidelines across forensic disciplines
4	**Adoption & Implementation of Advances**	Promote widespread adoption of improved methods, standards, technologies, and training across the forensic ecosystem

Table 5: Brief timeline of recent U.S. efforts to strengthen forensic science.[6,7,31,32,78,90]

Date	Event
November 2005	Congress authorizes the NAS to conduct a national study of forensic science.
February 2009	NAS issues *Strengthening Forensic Science in the United States: A Path Forward*, a landmark report proposing 13 major reforms.
February 2013	DOJ and NIST announce formation of NCFS and NIST-administered scientific guidance groups.
Sept 2013 – Apr 2014	OSTP establishes a research strategy working group (DOJ–NIST–NSF).
February 2014	NIST announces creation of OSAC (Organization of Scientific Area Committees) at first NCFS meeting.
February 2014	OSTP issues *Strengthening Forensic Science: A Progress Report*.
September 2016	PCAST releases *Forensic Science in Criminal Courts: Ensuring Scientific Validity of Feature-Comparison Methods*, calling for empirical validation, black-box studies, and federal action.
April 2017	DOJ discontinues NCFS as federal advisory body, ending formal DOJ–NIST joint forensic policy leadership.
2021–2022	Several states (e.g., Texas, New York) incorporate OSAC standards by reference or require labs to consider OSAC Registry standards in accreditation.

2022–2026	NIJ releases and implements its *Forensic Science Strategic Research Plan 2022–2026*, outlining national priorities: foundational research, applied methods, workforce development, and coordinated community practice.
September 2024	NIST issues *Strategic Opportunities to Advance Forensic Science in the United States: A Path Forward Through Research and Standards* (NIST SP-1319).
2025	NIJ publishes *Forensic Science Strategic Research Plan 2022–2026*, reaffirming federal investment priorities and partnerships.
2026 (Ongoing)	NIST continues scientific foundation reviews; NIJ continues research funding aligned with the 2022–2026 plan.

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REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Public Health Implications of Food Subsidies

EXECUTIVE SUMMARY

BACKGROUND. Policy H-150.915, "Public Health Implications of US Food Subsidies," adopted at the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) asked that our AMA study the public health implications of United States food subsidies, focusing on: (1) How these subsidies influence the affordability, availability, and consumption of various food types across different demographics. (2) Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases. (3) Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "food/farm/agricultural subsidies" AND "public health", "food/farm/agricultural subsidies" AND "diet," and "food/farm/agricultural subsidies" AND "nutrition." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the United States (U.S.) Department of Agriculture and applicable professional and advocacy organizations were also reviewed for relevant information.

DISCUSSION. Poor diet is a leading cause of morbidity and mortality, both in the U.S. and globally. Poor dietary habits include low intake of fruits, vegetables, and whole grains as well as excessive consumption of added sugars, saturated fats, and sodium, often via ultra-processed foods. Farm subsidies are monetary payments and other types of financial support provided by the federal government to farmers or agribusinesses. Agricultural subsidies in the U.S. primarily support the production of just a few commodity crops, namely corn, soybeans, cotton, and wheat, which are used heavily in ultra-processed foods, biofuels such as ethanol, and food for livestock. Additionally, a majority of agricultural subsidies go to large agrobusinesses and very wealthy individuals/corporations, while many smaller and independent, family-run farms receive comparatively little government assistance. One outcome of our current agricultural subsidy system is that many food groups recommended as part of a healthy diet, such as fresh fruits and vegetables, tend to be more expensive per unit of energy relative to less healthy and highly processed foods that rely on cheap commodity crops such as corn, soybeans, and wheat. There are limited studies that directly evaluate the impact of farm subsidies on health, but current evidence shows that individuals in the highest quartile of subsidized food consumption had higher probabilities of obesity, abdominal adiposity, and dysglycemia compared to the lowest quartile of consumption. Additionally, agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. These primarily include environmental contaminants/pollutants, climate change, and depletion of natural resources and areas.

CONCLUSION. Current farm subsidies support an agricultural system focused on commodity crops, such as corn, which fosters increased consumption of unhealthy foods and negatively impacts health. Agricultural practices incentivized by farm subsidies also have direct and indirect adverse impacts on the environment through a myriad of pathways. Strategies to improve the current system should prioritize the production and consumption of more fruits, vegetables, and whole grains.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-26

Subject: Public Health Implications of Food Subsidies

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

AMA Policy H-150.915, "Public Health Implications of US Food Subsidies," was adopted at the 2025 Annual Meeting of the American Medical Association (AMA) House of the Delegates (HOD) and states the following:

> Our AMA will study the public health implications of United States food subsidies, focusing on:
> 1. How these subsidies influence the affordability, availability, and consumption of various food types across different demographics.
> 2. Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases.
> 3. Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

METHODS

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BACKGROUND

Poor diet is a leading cause of morbidity and mortality, both in the U.S. and globally.[1] In the U.S., it has been estimated that about one million people die annually from diet-related chronic diseases, such as type 2 diabetes, cardiovascular disease, obesity, and some cancers.[2] Globally, noncommunicable diseases account for more than 70 percent of deaths and an estimated 40 percent are attributed to dietary factors.[3] Poor dietary habits include low intake of fruits, vegetables, and whole grains as well as excessive consumption of added sugars, saturated fats, and sodium, often via ultra-processed foods.[3] For example, the average adult in the U.S. only consumes two of the five recommended daily servings of fruits and vegetables while consumption of ultra-processed foods has steadily increased.[4,5] Additionally, according to the Centers for Disease Control and Prevention (CDC), Americans consume too many added sugars as part of their diet, which contributes to a number of health concerns, including excessive weight gain, type 2 diabetes, and

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heart disease.[6] High-fructose corn syrup is particularly concerning, as overall consumption increased by more than 1000 percent between 1970 and 1990 and it has little to no nutritional value as an additive.[7]

The health consequences of poor diet are inequitably distributed, with individuals from marginalized, communities of color and indigenous populations experiencing the worst diet-associated health outcomes.[8–10] Additionally, people with lower incomes generally have lower dietary quality and consume fewer fruits, vegetables and whole grains, but consume more refined grains, added sugars, and saturated fats compared to those with higher incomes.[11] Access to healthy, nutritious, and affordable foods is an important social determinant of health that is influenced by several upstream environmental, community and policy factors.[11] Agricultural policies, and specifically the U.S. Farm Bill and its associated food and farm subsidies, represent a critical component of the federal policy landscape impacting the U.S. food system. In the broadest sense, food subsidies are financial aid provided by the government to producers or consumers to make food more affordable or to support agricultural industries. On the consumer side, food subsidies in the U.S. most notably include the Supplemental Nutrition Assistance Program (SNAP), child nutrition programs, and emergency food assistance.[12] On the producer side, agricultural or farm subsidies (used interchangeably here) are monetary payments and other types of direct financial support provided by the federal government to farmers or agribusinesses.[13] Based on the whereas clauses included in the original resolution (Res 428-A-25) which prompted this report, the primary focus of this report will be on farm subsidies but will also briefly touch on consumer subsidies.

DISCUSSION

Farm subsidies were first institutionalized in the 1930s during the Great Depression and U.S. dust bowl, a time where crop prices had fallen considerably, rural areas were experiencing extreme poverty, and nearly a fifth of the U.S. population was still employed in the farm sector.[14] Food and farm subsidies are generally controlled by the U.S. Farm Bill, an omnibus piece of legislation that is normally reauthorized every five to six years and forms the basis of all or most of the agricultural policy in the U.S. A visual breakdown of how money is distributed under the U.S. Farm Bill as of 2018 can be seen in Figure 1. As of 2018, about three-quarters of the $428 billion allocated to the farm bill was intended for nutrition programs – namely SNAP.[15] Nine percent of funds were earmarked for crop insurance programs, seven percent for commodities, seven percent for conservation programs, and about one percent for miscellaneous programs.[15]

Farm subsidies, in particular the crop insurance program and commodity payments, are intended to help farmers deal with natural disasters and risk management while also incentivizing the development of specific farming practices and conservation efforts.[16] There are five general categories of agricultural subsidies, which include:

1. Direct payments, which are paid at a set rate every year regardless of sales or weather conditions.
2. Counter-cyclical payments are triggered when commodity market prices fall below certain thresholds.
3. A revenue assurance program provides for overall profitability for a given crop.
4. Marketing loans, which offer favorable terms whereby farmers can realize gains through loan deficiency payments and commodity certificates.
5. Disaster payments and crop insurance subsidies; disaster payments allow farmers to recoup large losses due to natural disasters or other ecological factors, and the government also subsidizes crop insurance to further insulate farmers from risk.[17,18]

Agricultural subsidies, historically and currently, primarily support the production of just a few commodity crops, namely corn, soybeans, cotton, and wheat. These crops are used heavily in ultra-processed foods, biofuels such as ethanol, and food for livestock.[19] For example, the U.S is the largest producer of corn in the world but a majority of corn produced is not used for direct human consumption. Corn is a major component of livestock feed, which accounts for nearly 40 percent of total domestic corn use, and another 35 to 40 percent of corn is used for biofuel production (see Figure 2).[20] Corn farms alone received approximately 30.5 percent of all federal farm subsidies, equaling $3.2 billion in 2024.[16] A very small percentage of U.S. farm subsidies are used to produce other fresh fruits and vegetables.

Additionally, a majority of agricultural subsidies go to large agribusinesses and wealthy individuals/corporations, while many smaller and independent, family-run farms receive comparatively little government assistance.[21] For example, one report found that between 2012 to 2020, the top 10 percent of farms (in terms of size), which also tend to be owned and operated by wealthier individuals, received 56.4 percent of all crop insurance subsidies, with the top 5 percent receiving 36.4 percent.[22] A Government Accountability Office report found that a recipient of agricultural subsidies in the form of insurance premium subsidies, whose annual gross income exceeded $900,000, received an average of $1.2 million annually in premium subsidies during the years 2009 to 2013, while participants whose annual gross incomes were less than $900,000 received an average of about $7,480 annually in premium subsidies during the same period.[23] Thus, current agricultural subsidies policy accumulates more benefits to wealthier farmers and does much less to support middle- and lower-income farms.[24] There are also important racial and ethnic disparities in the distribution of farm subsidies. U.S. farm subsidies have historically favored large, white-owned farms and have systematically marginalized African American and Indigenous farmers. These groups have and continue to face barriers in accessing government subsidies, such as United States Department of Agriculture (USDA) denying or delaying loans to African American and Indigenous farmers, resulting in substantial land loss and a widening racial wealth gap in agriculture.[19,25–27]

The downstream impacts of U.S. farm subsidies result from a complex system that is largely driven by the financial incentives provided for large-scale production of commodity crops, which both fuels the widespread availability of unhealthy foods while simultaneously promoting farming practices that contribute to environmental degradation. Figure 3 depicts a high-level conceptual causal pathway diagram that traces how U.S. farm subsidies impact agricultural production decisions which then influence both the consumer food environment and several environmental outcomes, all of which have public health impacts. The following two sections summarize the health and environmental impacts of farm subsidies.

Health Impacts of Farm and Food Subsidies

Public health proponents of reforms to farm subsidies have argued that subsidization of commodity crops, such as corn, fosters increased consumption of ultra-processed foods, sugar-sweetened beverages, and more meat and dairy products than were historically recommended by the U.S. Dietary Guidelines, as unhealthy foods are more widely available and cheaper than healthy alternatives as a result of farm subsidies.[7,28,29] Food groups recommended as part of a healthy diet, such as fresh fruits and vegetables, tend to be more expensive per unit of energy compared to many highly processed goods that rely on cheap commodity crops such as corn, soybeans, and wheat. For example, one study found the purchase price of ultra-processed foods was $0.55 versus $1.45 for unprocessed foods per 100 kcal.[30] This trend is not limited to the U.S. A report by the United Nation's Food and Agriculture Organization found that vegetables were on average nine times more expensive than starchy food staples worldwide.[31] See Figure 4 for a helpful visual comparing the

global prices of different food categories per kilocalorie. Additionally, the availability of vegetables for consumption in the U.S. has been steadily declining for the last two decades while the domestic availability of meat has increased.[32,33]

The 2017 AMA Council on Science and Public Health report on sugar-sweetened beverages referenced a 2016 study that found individuals consuming the highest amounts of foods made from subsidized commodities have a 14 to 41 percent higher probability of cardiometabolic risk as measured by BMI, abdominal adiposity, C-reactive protein, and lipid levels.[34] An updated version of this study published in 2020 using more recently available data found consistent results. Namely, those in the highest quartile of subsidized food consumption had higher probabilities of obesity, abdominal adiposity, and dysglycemia compared to the lowest quartile of consumption, although some associations were significantly weakened from the previous years of study.[35] However, the authors note that U.S. consumption of foods created with subsidized crops has declined since the previously published study, from 56 percent to 51 percent.[35] This finding aligns with steady a decline of corn being used to create high fructose corn syrup in recent years, from around five percent in 2016 to three percent in 2024, which can be attributed to several factors, including changes to consumer preferences and the increasing proportion of corn being used as biofuel.[29,36,37]

Beyond sugar-sweetened beverages, another pathway through which agricultural subsidies impact the American diet is the consumption of meat. In general, grain-fed animals gain weight faster and become fatter than pasture-fed animals with diets lower in grains. Thus, the lower cost of feed makes it faster and cheaper to raise poultry, hogs, and cattle, which translates to relatively low costs for meat products.[7] As of 2025, the USDA estimates that the average American will consume about 60 pounds of beef and about 100 pounds of poultry per capita each year.[33] Americans are among the top per capita meat consumers in the world and are estimated to eat more than 1.5 times the average daily protein requirement due to high meat consumption.[38] Diets with higher meat consumption, particularly of red and processed meat, are correlated with the occurrence of several chronic diseases and acute health conditions, including high cholesterol, heart disease, stroke, obesity, certain cancers, type 2 diabetes, and premature death.[7,38,39] Additionally, there is some evidence that pasture-raised animals are better for consumers' health than heavily grain-fed animals since pasture-raised animals tend to have lower calories and total fat, higher levels of vitamins and good fatty acids, and a healthier balance of omega-3 and omega-6 fats.[40,41]

There are limited studies, beyond the ones referenced above, that quantify the impact of agricultural subsidies in their current form on dietary shifts and their resulting health outcomes. However, several studies have used modeling approaches to estimate impacts from taxes on certain food (e.g., sugar sweetened beverage taxes) and subsidizing the *purchase* of fresh fruit and vegetables. There is an important distinction between subsidies for consumers to purchase fruit and vegetables versus subsidies for farmers to grow produce beyond the few commodity crops mentioned above. The following studies address subsidized purchases, not subsidized production.

A modeling study published in 2020 compared the effects in New Zealand of a 20 percent fruit and vegetable subsidy, taxes on foods high in saturated fat, sugar, and salt, and an 8 percent junk food tax.[42] Models estimated a positive impact on health-adjusted life years per 1000 people for all the policies, ranging from 127 for the junk food tax, 212 for the fruit and vegetable subsidy, to 581 for the sugar tax. The study also reported significant health expenditure savings across the remaining lifespan per capita ranging from nearly $500 to over $2100 depending on the policy.[42] A similar study was done to simulate the effects of these types of food policies in the Australian population. In this study, taxes on sugar, salt, saturated fat, and sugar-sweetened beverages were estimated to have strong net positive health gains. The authors note that while fruit and vegetable purchasing

subsidies are a cost-effective addition to taxes, they do not lead to significant health benefits when modeled as a standalone intervention.[43]

SNAP is the largest food subsidy and nutrition assistance program in the U.S. which provides roughly 40 million low-income Americans with monthly benefits to purchase groceries.[12] SNAP has been demonstrated to reduce health care costs, improve health outcomes, and has been referred to as the nation's most important anti-hunger program.[44] SNAP functions as a prevention strategy against food insecurity, which is associated with several negative health outcomes across the lifespan. SNAP health benefits include better self-reported health, lower risk of heart disease and obesity among adults who had access to SNAP earlier in life, higher likelihood of periodic medical check-ups for infants and children in participating families, and greater medication adherence among older participants.[44]

Environmental Impacts of Farm Subsidies

Agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. Due to the nature of our current agricultural subsidy system and its incentives, the production of just a few commodity crops by large companies represent an overwhelming amount of agricultural production, and these therefore play a large role in the environmental impact of agriculture.[45] There are a few broad categories of environmental impact tied to the food system; these primarily include environmental contaminants/pollutants, climate change, and depletion of natural resources and areas.[45]

Environmental contaminants and pollutants. Agricultural production, at nearly every stage of the process, is associated with the release of environmental contaminants and pollutants, which include nutrients, such as nitrogen and phosphorous; pesticides; pharmaceuticals; pathogens; and air pollutants/gases (e.g., ammonia, methane, and fine particulate matter).[45] What follows is a high level summary of these issues and their impacts to the environment and public health.

Nutrients such as nitrogen, phosphorous, and potassium are essential for plant growth. Fertilizers, both organic and synthetic, are commonly applied during agriculture to provide these nutrients and promote higher crop yields. Organic fertilizers are derived from natural resources, such as decomposed plant matter or animal waste, while synthetic fertilizers are manufactured with blends of chemical compounds, with generally higher concentrations of nutrients.[46] Global agricultural use of synthetic fertilizers has increased fivefold since the 1960s, which increases the amount of nitrogen entering the environment. Synthetic fertilizers greatly increase the nutrient load in soil within a short amount of time, which impacts water quality through runoff. This includes nitrates entering groundwater systems as well as rivers and coastal areas. Nitrogen oxides and nitrous oxide are also released as an air pollutant into the atmosphere.[47] Nitrogen oxides contribute to air pollution, irritate the respiratory system, and can react with other chemicals and water in the atmosphere to create acid rain.[48] Acute, low levels of exposure to nitrous oxides can irritate the eyes, nose, throat, and lungs and cause coughing, shortness of breath, tiredness, and nausea.[49] Nitrogen, phosphorus, and other plant nutrients in surface water contribute to algae blooms that can foul drinking and recreational water systems and sometimes poison pets or wild animals.[50]

Another well-studied environmental concern from agriculture is pesticides. Pesticides are commonly and extensively used in agriculture to increase crop yields and to protect crops from pests that could reduce yield production. Types of pesticides include herbicides, insecticides, fungicides, and rodenticides. An estimated two million tons of pesticides are used globally each year.[51] The move towards large scale monoculture agriculture is associated with an increase in the use of pesticides in order to compensate for each crop's susceptibility to disease from specific

pathogens.[52] The level of toxicity for any pesticide depends on the type of pesticide and its chemical structure, its mode of entry, the dose, and the exposure period.[53]

Due to the relatively low cost of subsidized grains, another outcome from the current industrial agricultural system supported is the growth in Concentrated Animal Feeding Operations (CAFOs). CAFOs are a specific type of large-scale industrial agricultural facility that raises animals, usually at high density, for the consumption of meat, eggs, or milk. CAFOs are reflective of a major shift that has occurred within the U.S. agricultural system in the past 60 years, from one previously characterized by small and medium-sized farms to one that is now dominated by much larger operations that concentrate large numbers of animals in relatively small geographic areas. The primary environmental and public health concern from CAFOs is the large volume of manure produced by animals, which contain potential contaminants and can negatively impact local air quality and water systems.[45] Local communities around CAFOs suffer from lower quality of life due to the intensity of odors, gaseous emissions, insect vectors, and diseases spreading from the farms. There is an important environmental justice aspect to these exposures, as swine CAFOs have been found to be disproportionately located near rural, low-income African American communities in some parts of the country.[54]

As noted above, one major concern with CAFOs is the large amount of animal waste that is produced which then needs proper disposal. This creates another agricultural pollutant: pathogens. Pathogens from animal waste can infect other animals, can infiltrate local water supplies, and can be spread onto other agricultural products through the application of fertilizer in the form of animal waste. Despite vast improvements in food safety over the last century, there are still millions of human foodborne illnesses that occur every year.[55,56] There are also distinct risks from cross-species pathogens from the raising of livestock, particularly with CAFOs, and the potential risk of disease in other animals and humans. One recent example came from the highly pathogenic avian influenza A (H5N1), which spread quickly among poultry farms and then to dairy cows and subsequently infected a small number of farm workers, who were primarily Latino migrant workers.[57,58] One study found that agricultural intensification over the past several decades is associated with an increased risk of zoonotic disease emergence and that the future of zoonotic diseases will be closely linked to the evolution of our agricultural systems.[59]

As a protective measure, many farms will proactively give animals antibiotics to mitigate the risk of infection and quick spread of pathogens in CAFOs. As a result, CAFOs have also been implicated in concerns over growing antibiotic resistance and the contamination of natural systems with pharmaceutical byproducts, as the animals being held in CAFOs often must consume large amounts of antibiotics to survive within the cramped and compact conditions. The growing evidence of the environmental and public health harm caused by CAFOs has resulted in major public health and medical organizations adopting policies on them. Farm workers and nearby communities are exposed to numerous air pollutants from CAFOs, including particulate matter, ammonia, hydrogen sulfide, volatile organic compounds, noxious fumes, microorganisms, and endotoxins.[60–62] In 2019, the American Public Health Association approved the policy, "Precautionary Moratorium on New and Expanding Concentrated Animal Feeding Operations," and in 2023, the AMA adopted policy H-135.908, "Public health implications of industrialized farms," which recognizes CAFOs as a public health hazard.[63,64]

Climate Change. Agriculture is a major contributor to U.S. greenhouse gas (GHG) emissions and accounts for almost 11 percent of U.S. GHG emissions.[19] GHG emissions associated with agriculture are heavily concentrated in a few commodities, namely those having to do with cattle (e.g., beef and dairy), as cows produce substantial methane emissions with their ruminant digestive process, and from nitrous oxide emissions from activities like fertilizer application and storage of

manure.[65,66] In fact, nitrous oxide generated by agriculture is estimated to be responsible for about eight percent of total global anthropogenic GHG warming as of 2021.[47] Subsidies can play an important role in impacting GHG emissions associated with agriculture, as they influence how much is produced, what is produced, where it is produced, and how goods are produced.[67] One modeling study analyzing data from countries that participate in the Organisation for Economic Co-operation and Development (OECD) found that agricultural subsidies had the effect of increasing production of crops and GHG emissions, but results were variable across countries and were highly dependent on the commodities grown and technology used.[65]

While current agricultural practices exacerbate climate change, climate change itself impacts agricultural production through a variety of pathways. For example, climate change threatens food supplies by increasing the risk of flooding and extreme rain events, which can lead to contamination of food and water and destroy crops. At the same time, climate change can lead to increased drought and hotter temperatures in other parts of the country that could damage crops and harm livestock.[19,47] This current dynamic and negatively reinforcing relationship between agriculture and climate change is one that could be used as a powerful lever for positive change and climate change mitigation if subsidies were redesigned to promote more sustainable practices across the industry

Depletion of natural resources and areas. Our current agricultural system contributes to the depletion of natural resources, most importantly, healthy soil, freshwater, and natural areas, which is also tied to biodiversity. The critical importance of soil health for the future of agriculture cannot be understated. While soil erosion is a natural process, it has been identified as one of the most important land degradation processes that occurs with agriculture. Soil creation is a long-term geological process and one that is unable to keep up with current rates of erosion from agriculture. Erosion processes deplete organic matter within the soil and reduce its overall fertility and water holding capacity.[45] This last point creates a positive feedback loop – as soil continues to erode, it has less water holding capacity and therefore is more likely to have increased runoff, which furthers the process of erosion.[45] Agricultural runoff is a leading cause of pollution to rivers and streams, lakes, and impairments to wetlands.[68] While crop yields have generally increased over the past century, this has largely been from technological advances, including more intensive use of fertilizers, which for the time being has been able to mask potential effects of continuous soil degradation.[45] While monoculture farming increases productivity of single crops, it contributes to faster degradation of soil and its fertility, and requires a higher use of fertilizers.[52]

Fresh water is crucial for agriculture. In the U.S., agriculture is a major user of ground and surface water. Irrigation accounts for 47 percent of our nation's total freshwater withdrawals from both sources between 2010 and 2020.[69] Irrigation for cropland is highly geographically dependent, with a large majority of the irrigated land concentrated in western states where the production of many crops requires irrigation due to a more arid climate.[69] Irrigation for agriculture is a primary culprit for groundwater depletion – defined as long-term water-level declines caused by sustained groundwater pumping – which is a major sustainability issue and being felt acutely in the High Plains region of the U.S. (including the Ogallala aquifer) and other aquifers in the Mountain West and Southwest.[70,71] Corn and soybeans, which are also the most subsidized commodity crops in the U.S., are a few of the crops with the highest water consumption demands.[71,72] Reduced groundwater levels are not just a threat to the sustainability of our current food production system, but also have other adverse impacts, including land subsidence, increased costs for users as it becomes increasingly difficult to pump water from underground aquifers, and reduced water quality primarily due to saltwater intrusion.[71]

The intensification of agricultural production over the last 50 years has led to the expansion of agricultural lands into previously natural areas, which has put pressure on existing wild habitats and species and negatively impacted biodiversity.[47] According to the U.S. Environmental Protection Agency, nearly 1.2 billion acres of the nation's 2.3 billion acres are devoted to agriculture.[68] Due to changes in the U.S. Farm Bill in 1990, annual acres planted for both corn and soybeans crops, the two biggest U.S. crops in terms of total production, have increased by 14 and 26 million, respectively, over the last 35 years.[73] Ironically, declines in biodiversity caused by the expansion of agriculture and the increased use of fertilizers and pesticides, has resulted in a reduction in the number and variety of pollinators as well as natural predators for common agricultural pests, which has an overall net negative impact on current agriculture and creates a positive feedback loop in terms of necessitating increased use of synthetic inputs in the future.[74] The loss of biodiversity has also been found to increase the risk of human exposure to both new and established zoonotic pathogens.[75] Agricultural ecosystems have also become less diverse as monoculture farming has expanded, which has the effect of reducing national food security and stability.[76]

Agricultural Sustainability. While sustainability has many facets, agricultural sustainability aims to meet current food and resource needs without compromising the ability of future generations to do the same.[77] Pillars of sustainable agriculture include building healthy soil and preventing erosion, effective water management, minimizing air and water pollution, reducing climate warming emissions, increasing climate resilience, and promoting biodiversity.[77,78] There are many types of sustainable agricultural practices, and they tend to be most effective when used in combination. A few examples include:

- Rotating crops on a regular basis and planting a variety of crops, which creates healthier soil and improves pest control.
- To help reduce soil erosion, planting cover crops during the off-season and perennial plants to maintain living roots in the soil year-round.
- Creating nutrient management and targeted irrigation strategies to help reduce the application of excessive nutrients and water runoff.
- Integrated pest management approaches to help reduce the use of chemical pesticides.
- Agroforestry, a practice in which trees and shrubs are incorporated into fields, which provide shade and shelter for plants and animals that may be beneficial in controlling pests.
- Developing a systems approach to farmland management that treats uncultivated or less intensively cultivated areas as integral to the farm ecosystem.[78]

Improving the Farm Bill for Health

Multiple health and medical organizations agree that a diet aimed at achieving optimal human and planetary health should prioritize a wide variety of whole and minimally processed plant foods including vegetables, fruits, whole grains, and legumes, with moderate inclusion of animal-sources foods, while minimizing red and processed meats, foods high in saturated fat, and ultra-processed foods.[79–81] Aligned with this dietary guidance, several health-related associations have developed recommendations for future reauthorizations of the U.S Farm Bill to improve health and sustainability. Recommendations include increased subsidies for fruit and vegetable production, creating incentives for sustainable agricultural practices, conservation efforts, and more equitable distribution of subsidies that help diversify crops and improve equity within rural farming communities that have been historically excluded from federal agricultural assistance programs.[19,82] For example, the Society for Behavioral Medicine has recommended the inclusion of fruits and vegetables in commodity programs, providing additional insurance subsidies for producing fruits

and vegetables, and developing new insurance programs geared towards fruit and vegetable production.[82] Another recommendation is to establish financial incentives that increase funding for organic agriculture practices and prioritize sustainable agricultural practices in government-funded farm-to-table institution programs.[83] Other important focus areas for increased research and funding would be restorative agriculture, precision farming techniques, improving resilience in the face of climate change, and agricultural practices that take a broader ecological approach that considers its role within the larger environmental context.[19,45]

Many of the other recommendations for the U.S. Farm Bill focus on nutritional assistance and improving accessibility of healthy foods for consumers. A common theme in these recommendations is that the U.S. Farm Bill should incorporate a 'food is medicine' framework.[83] The 'food is medicine' framework is defined as the provision of healthy food resources or interventions in coordination with the healthcare sector to prevent, manage, or treat specific clinical conditions.[84] Specific interventions within a food is medicine approach includes medically tailored meals, produce prescriptions, medically tailored groceries, and nutrition counseling. So, for example, the Society for Behavioral Medicine has recommended that a reauthorization of the Farm Bill should increase the amount of funding available for produce prescription programs through the Gus Schumacher Nutrition Incentive Program.[83]

The other major theme of recommendations from medical professionals and associations includes continued and increased federal spending to support nutritional assistance programs, namely the Women, Infants and Children (WIC) program and SNAP. Continued and increased federal funding to support the WIC program and SNAP benefits is crucial for improving accessibility to healthful and nutritious food and reducing insecurity among low-income individuals and families in the U.S.[19,83,85] Other initiatives aimed at consumers to assist in purchasing healthy foods funded by the U.S. Farm Bill include the Food Insecurity Nutrition Incentive program and the Healthy Food Financing Initiative. The Food Insecurity Nutrition Incentive program is a grant-based program which provides financial incentives for families to purchase healthy foods while the Healthy Food Financing Initiative is designed to stimulate economic development and job creation by supporting farmers and healthy food retailers in low-income communities, underserved communities, and communities of color.[85] There is strong evidence that incentive programs like these can have positive impacts on health. The Community Preventive Services Task Force has recommended fruit and vegetable incentive programs as an important community-based program based on strong evidence of effectiveness in reducing household food insecurity and increasing household fruit and vegetable consumption.[86]

Other recommendations to update the Farm Bill to improve health include increased consumer education and increased nutritional research funding. Specifically, the Academy of Nutrition and Dietetics recommended increased funding for nutrition education programs that empower communities to develop skills to choose healthful diets and reduce the risks of developing chronic disease that are done in conjunction with nutrition assistance or delivery programs.[85] Research funding should also be increased to improve our understanding of the connections between nutrition, our food system, and accessibility by supporting existing initiatives and centers, for example the Agricultural and Food Research Initiative and the Agricultural Research Service's Human Nutrition Research Centers.[85]

Current Regulatory Landscape

The last time the U.S. Farm Bill was officially reauthorized was in 2018. However, there were important components normally considered in the Farm Bill that were included in H.R.1, dubbed by its proponents as the "One Big Beautiful Bill Act." Passed in July 2025 through budget

reconciliation, H.R. 1 covers several major farm bill provisions and funds them through 2031. However, the funds allocated for SNAP in H.R. 1 represent one of the largest cuts to SNAP funding in its history, equaling approximately $187 billion in cuts through 2030. Additionally the bill created new cost-sharing requirements for states and stricter work requirements for recipients.[87] These funding cuts and changes are estimated to reduce or eliminate SNAP benefits for nearly four million Americans.[87]

H.R. 1 also included provisions related to agriculture subsidies for commodities and crop insurance. The bill increased reference prices for covered commodities like wheat, corn, and soybeans and payment limits were increased for commodity programs. Funding for important crop insurance programs were extended and expanded. Affordability issues were partially addressed through expansion of premium assistance for beginning farmers and ranchers and a new pilot program for poultry insurance was created. The bill also made permanent certain 2017 tax provisions beneficial to family farms and ranches, including increased estate tax exemptions and enhanced business expensing options.[88–90]

H.R. 1 also restructured funding that had been obligated for climate-specific conservation funds under the Inflation Reduction Act into a permanent farm bill baseline funding pool.[89] The high level summary from one organization, the National Sustainable Agriculture Coalition, notes that the agricultural provisions in H.R. 1 increased subsidies for large commodity growers (even though they already primarily benefit from that program), included little to no support for smaller farmers and those that grow diversified crops, made drastic cuts to nutrition assistance programs, preserved some conservation efforts, and ultimately delayed the passage of a comprehensive farm bill that is overdue.[88] However, in November 2025, Congress passed an omnibus appropriations package that extended the remaining 2018 Farm Bill provisions until September 30, 2026, including the Conservation Reserve Program, that were left out of H.R. 1.[92]

EXISTING AMA POLICY

AMA has several existing policies that recognize the unhealthy contribution of excessive sugars in the American diet and encourages healthier food option availability.[34,93–95] Additionally, AMA Policy H-150.932, "Reform the U.S. Farm Bill to Improve U.S. Public Health and Food Sustainability," supports the creation of a new advisory board to review and recommend U.S. Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.[96] Policy D-150.978, "Sustainable Foods," supports practices and policies in medical schools, hospitals, and other health care facilities that model a healthy and ecologically sustainable food system… [and] evidence-based policies and programs to eliminate disparities in healthy food access…such as tax incentive programs, community-level initiatives and federal legislation.[97] Policy D-150.944, "Combating Obesity and Health Disparities," supports the provision of vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs as well as federal subsidies that encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.[98] Policy H-135.908, "Public health implications of industrialized farms," recognizes CAFOs as a public health hazard.[64] In a related report, CSAPH published a 2017 report on sugar sweetened beverages that included a section on the role of U.S. farm subsidies in the American diet and related health impacts.[34] AMA also has several policies on SNAP that support continued and increased funding for the program to improve diet and nutrition for all Americans.[99,100] Lastly, in March 2024, AMA joined the Medical Society Consortium on Climate and Health and 78 other health care organizations in sending a letter to the House of Representatives Agriculture Committee on the U.S. Farm Bill reauthorization, emphasizing the

importance of supporting a farm bill that prioritizes affordable and nutritious food as well as clean air and water.[101]

CONCLUSION

While U.S. farm subsidies were historically intended to stabilize the agricultural sector and produce enough food for Americans during challenging times, the nature of the U.S. food and agricultural system has changed drastically over the past 100 years. Currently, farm subsidies disproportionately benefit large, corporate farm operations and support an agricultural system focused on commodity crops, such as corn. This system fosters increased or excessive consumption of less healthy foods, such as unhealthy ultraprocessed foods, which are often more widely available and cheaper than healthy alternatives partly because of farm subsidies. Despite improvements in production efficiencies, agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. These include environmental contaminants and pollutants, climate change, and depletion of natural resources and areas. Strategies to improve the current food subsidy system should include increased subsidies for fruit and vegetable production, incentives for sustainable agricultural practices and conservation efforts, and more equitable distribution of subsidies that help diversify crops and improve equity for small producers that have been historically excluded from federal agricultural assistance programs.

RECOMMENDATIONS

The Council on Science and Public Health recommends that AMA Policy H-150.932, "Reform the US Farm Bill to Improve US Public Health and Food Sustainability," be amended by addition and deletion to read as follows and the remainder of the report be filed.

~~Reform the US Farm Bill to Improve US Public Health and Food Sustainability:~~ Our American Medical Association will advocate for ~~supports~~:

- Increased subsidies for the production of a diversity of health-promoting, whole foods, including fruits and vegetables;
- Reallocation of existing subsidies to improve equity for farmers that have been historically excluded from or underfunded by federal agricultural assistance programs;
- Increased funding for financial incentives, programs, and research initiatives to support sustainable agricultural practices, restorative agriculture, conservation efforts, and other projects that improve ecological diversity and resilience to climate change;
- Strengthen funding for U.S. Farm Bill initiatives which incorporate a 'food is medicine' approach and support interventions such as medically tailored meals, produce prescriptions, medically tailored groceries, nutrition counseling, and evidence-based education on preparation of healthy food; and
- the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Modify Current HOD Policy)

Fiscal Note: Minimal

APPENDIX

Figure 1: Breakdown of U.S. Farm Bill allocations as of 2018[15]

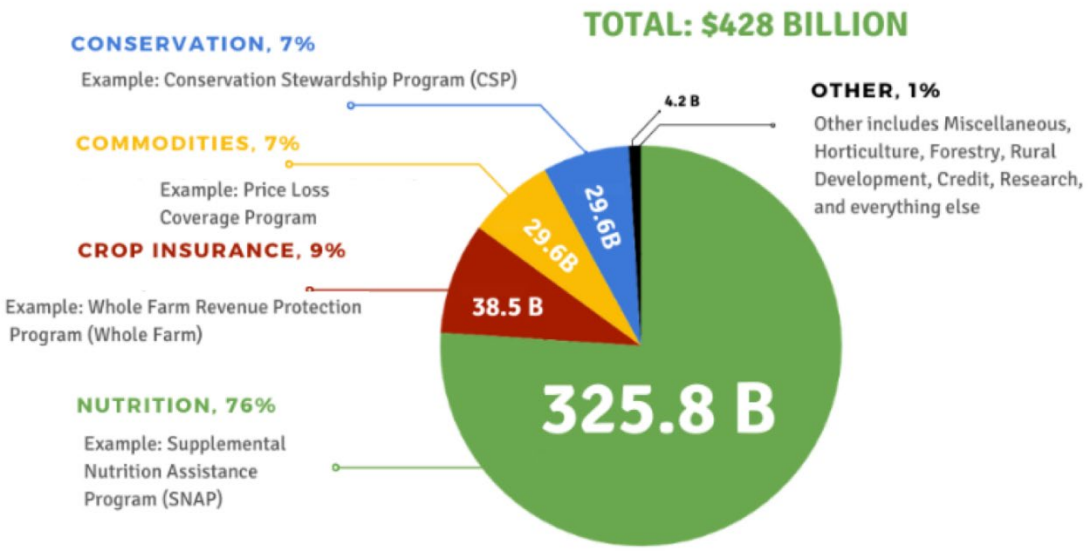


Figure 2: Historial data on U.S. Domestic Corn Use[20]

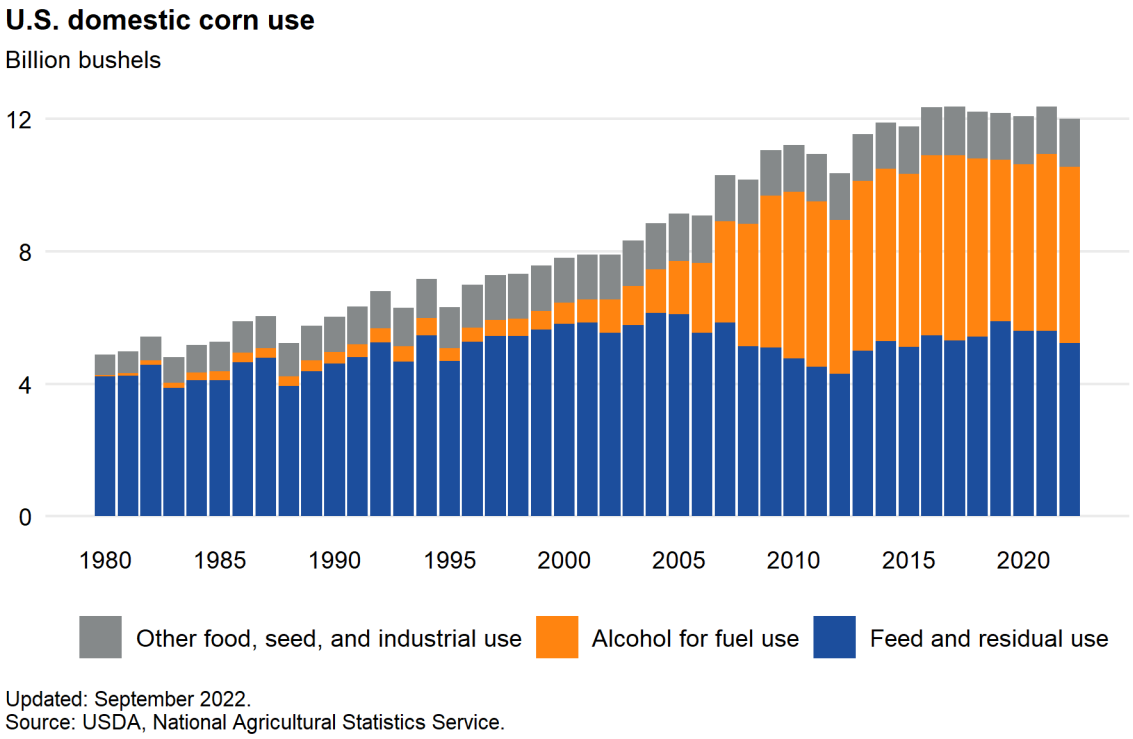


Figure 3: Conceptual pathway diagram illustrating the relationship between U.S. Farm Subsidies and downstream public health impacts

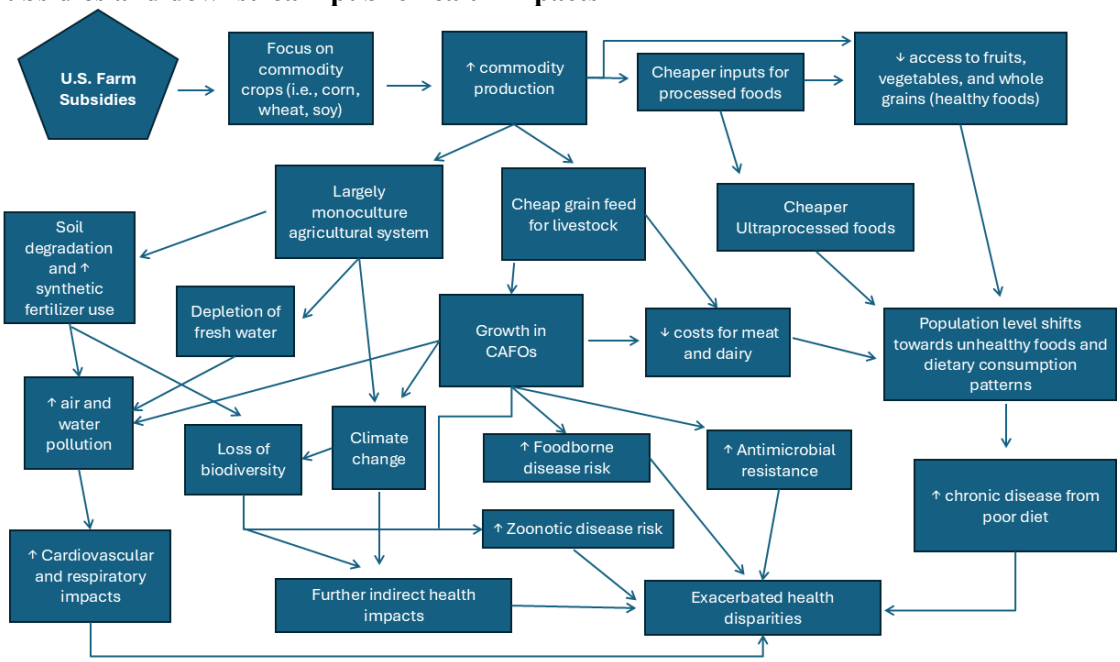
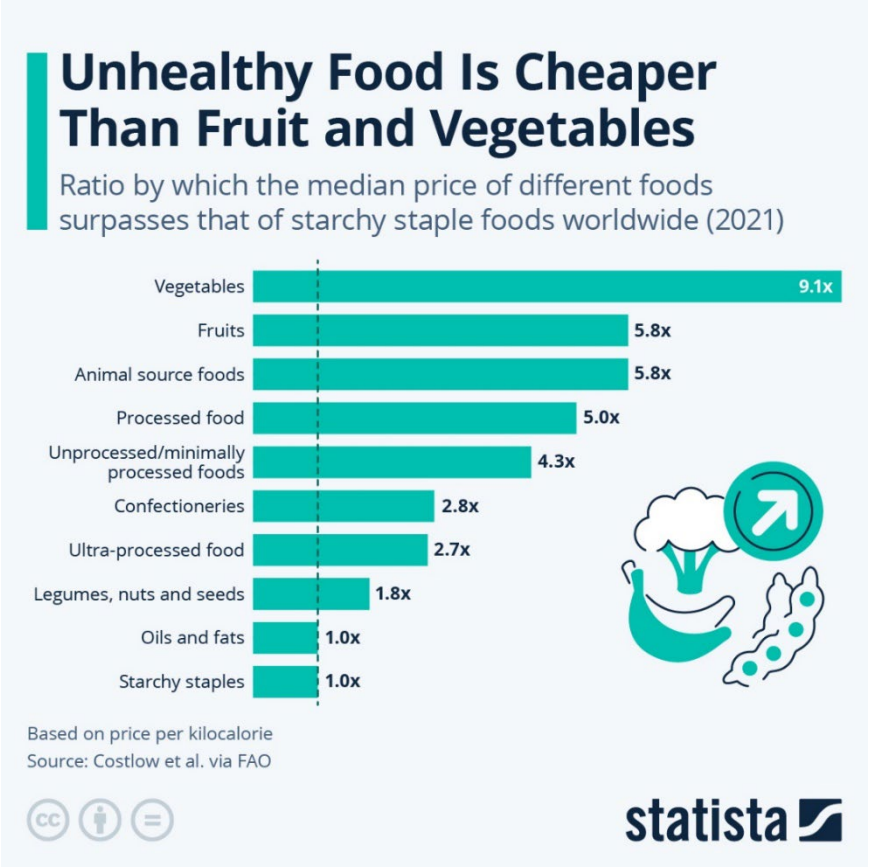


Figure 4: Comparative prices of different food groups based on total kilocalories[31]



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REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

EXECUTIVE SUMMARY

BACKGROUND: Resolution 404-A-25, "Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers" was referred for study. This report outlines the current state of low-dose computed tomography (LDCT) for lung cancer screening (LCS) including: (1) disease prevalence, screening rates, and high-risk populations, (2) risks, benefits, and evidence of effectiveness and potential future applications (3) barriers to and disparities in screening, and (4) current efforts to promote awareness among physicians and the public.

METHODS: English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "lung cancer screening" AND "low dose CT." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

DISCUSSION: Lung cancer has significant health and economic impacts in the U.S. It is the second most common cancer, is generally diagnosed at late stages, and consequently comes with a poor prognosis. Moreover, these effects are often more prevalent among marginalized individuals. Fortunately, there is evidence that LDCT has a high sensitivity and specificity for detecting lung cancer. Targeted screening can result in earlier diagnosis and better health outcomes like reduced lung cancer-specific mortality, yet screening rates remain low. Consequently, significant research efforts evaluate the barriers to and disparities in LDCT for LCS as well as efforts to address those barriers and improve LDCT LCS rates. Most of the current interventions to improve LDCT LCS focus on either improving education or addressing structural barriers. There is some evidence that educational interventions, particularly those that use shared decision-making (SDM), improve knowledge and awareness for both patients and clinicians. However, even with increased use of SDM screening, screening rates remain low, suggesting greater emphasis should be put on evaluating ways to improve SDM or on interventions that address structural barriers. Early efforts to bring LDCT to underserved areas (e.g., mobile LDCT and telehealth) or facilitate patient navigation (e.g., centralized programs, scheduling support, reminders, transportation) may improve screening rates but there is a clear need for more research to confirm the evidence of effectiveness, feasibility, and scalability.

CONCLUSION: There have been substantial efforts to better understand low LDCT LCS rates and disparities. Evidence supports continued efforts to improve knowledge and awareness with educational interventions, particularly those that use SDM. However, persistent low screening rates despite SDM efforts demonstrate the need for continued research into optimal methods of implementation as well as into interventions that address logistical and structural barriers. Currently, efforts to bring LDCT to underserved areas or facilitation of patient navigation have shown promise, but ultimately more research is needed to confirm the evidence of effectiveness, feasibility, and scalability.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-26

Subject: Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 404-A-25, "Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers," was referred for study and asked the following:

> That our American Medical Association will partner with other professional and public health organizations as well as key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to increase awareness amongst chronic smokers (who would benefit from appropriate lung cancer screening) regarding their risk for both lung cancer and coronary artery disease and encourage their participation in screening programs through a joint public campaign effort; and be it further
>
> That our AMA promote physician education and awareness regarding the value of chest CT in detecting both lung cancer and calcified atherosclerotic plaque and encourage reporting the extent of coronary artery calcification in non-contrast chest CT studies performed as a part of lung cancer screening program.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "lung cancer screening" AND "low dose CT." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKGROUND

Lung cancer is the second most commonly diagnosed cancer in the United States (U.S.), is generally detected at late stages, and consequently comes with a poor prognosis.[1–3] Early-stage lung cancer is more amenable to treatment and has a better prognosis; however, it requires early detection. Fortunately, there is evidence that low-dose computed tomography (LDCT) has a high sensitivity and specificity for detecting lung cancer.[4–12] Moreover, targeted screening can reduce lung cancer-specific mortality.[5,8–16] Despite the benefits of LDCT for lung cancer screening (LCS), rates of screening remain low.[17–22] This report outlines the current state of LDCT for LCS including: (1) the evidence of effectiveness, (2) disease prevalence, screening rates and high-risk populations, (3) barriers to and disparities in screening, and (4) current efforts to promote awareness among physicians and the public.

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DISCUSSION

The Lung Cancer Landscape: Prevalence, Mortality, Risk Factors, and Disparities

The 2026 Cancer Statistics report estimates 229,410 new cases of lung cancer will be diagnosed in the U.S. this year.[23] Although lung cancer incidence is falling, it remains the leading cause of cancer deaths in U.S. men and women (19 percent and 21 percent respectively).[23,24] Most patients diagnosed with lung cancer present with distant or metastatic disease which is harder to treat and associated with higher mortality.[25,26] Notably the five-year relative survival for lung cancer has improved steadily, rising from 12 percent in 1975–1977, to 15 percent in 1995–1997, and reaching 28 percent in 2015–2021.[23] In addition to loss of life, lung cancer caused approximately $13 billion in lost earnings in the U.S. in 2019, not to mention the $1.35 billion in patient out-of-pocket costs associated with lung cancer treatment and caregiving.[27–29] Furthermore, there is evidence that cancer costs increased by stage with statistically significant and economically meaningful differences between the lower cost of early-stage cancer compared to higher cost late-stage cancer.[30,31] The risk of developing lung cancer is primarily driven by smoking status, with 80 to 90 percent of lung cancer deaths linked to smoking.[3,32,33] Although, smoking prevalence dropped from 42 percent in 1964 to 11 percent in 2023, it continues to be the leading cause of preventable death in the U.S.[23,34] Other risk factors for lung cancer include environmental exposures (e.g., radon, heavy metals, asbestos, arsenic), radiation therapy, other noncancer lung diseases, race/ethnicity, and family history.[3,25]

Factors that impact smoking behaviors have a significant impact on lung cancer rates. Historically, men had higher rates of smoking and a higher incidence of lung cancer. However, recently men have shown steeper reductions in lung cancer incidence compared with women, who took up cigarette smoking later and were slower to quit.[23,27,35] Age also increases lung cancer risk as more than half of diagnoses occur at age 70 years or older, and 83 percent occur at age 65 years or older.[36]

Notably, tobacco marketing efforts have historically targeted members of marginalized and underserved communities, who often have the highest incidence and mortality from the disease.[27,37–41] Native American people have the highest lung cancer mortality at 38.7 per 100,000 compared with 34.5 per 100,000 in White people, who rank second, and 33.1 per 100,000 in Black people, who rank third.[23] There is also evidence that Black males have the highest rates of age-adjusted lung cancer incidence and lung cancer mortality of all U.S. racial/ethnic groups.[39,41] Generally, Black individuals tend to develop lung cancer at an earlier age and are diagnosed at a later stage than white individuals.[39,42,43] Trends are also less favorable for Asian American, Native Hawaiian, and Pacific Islander women, among whom lung cancer incidence is increasing.[27] Evidence also shows that American Indian/Alaskan Natives have the highest overall prevalence of cigarette smoking and the slowest decline in lung cancer incidence of any group.[27,34,39,41,44] Incidence rates declined fastest in Black individuals in the last 10 years.[27] There is also evidence that lung cancer disproportionately affects people of low socioeconomic status, who experience more environmental exposures, higher lung cancer mortality, and have fewer resources and are less able to manage the economic burden of screening and treatment.[27,39,45–47]

Geography also impacts lung cancer rates and mortality. Rural populations experience particularly stark disparities in lung cancer outcomes including higher rates of smoking, a higher incidence of lung cancer, greater late-stage diagnosis, and have higher lung cancer mortality.[48–51] This is particularly true for Black individuals in rural areas when compared than those in urban areas.[39,52] State to state differences are notable and often tied to historical smoking trends.[27]

Recommendations for Lung Cancer Screening with LDCT

LDCT converts a series of x-ray images to create 3-D views of tissues and organs, but uses significantly less radiation than regular CT, thereby decreasing the radiation exposure risk.[53] Lung cancer screening guidelines recommend annual screening with LDCT as it has a moderate net benefit in persons at high risk of lung cancer based on age, total cumulative exposure to tobacco smoke, and years since quitting smoking.[54] However, there is slight variability in the screening guidelines regarding age and pack year cutoffs. (See Table 1).

Benefits of LDCT: screening efficacy, lung cancer mortality, incidental findings, and future applications

There is strong evidence from multiple systematic reviews, meta-analyses, and other studies that LDCT has high sensitivity and specificity to detect lung cancer.[4–12] There is also a well-defined high-risk population that may benefit from LCS with LDCT as LDCT is associated with increased diagnosis of early-stage non-small cell lung cancer (NSCLC), increased rates of resection, and a significant reduction in lung cancer-related mortality.[5,8–15,38,55–62]

Furthermore, some researchers and clinicians suggest that LDCT for LCS may be a useful tool to diagnose other cardiovascular and pulmonary conditions (e.g., ischemic heart disease, COPD, coronary artery disease) in otherwise asymptomatic patients.[63–71] LDCT for LCS provides images of the entire chest and upper abdomen and using a single scan to evaluate multiple conditions could reduce radiation exposure, save time, and decrease costs.[63,64] Cardiovascular conditions like coronary artery calcification (CAC), increase with age, are more common in smokers, and are frequently noted on LCS LDCT scans.[55,65,72,73] Additionally, although the clinical standard for evaluating CVD risk via CAC requires a dedicated ECG-synchronized cardiac CT, it can also be measured on any standard protocol CT image that includes complete imaging of the heart such as routine noncontrast-enhanced, non-ECG gated chest CT (NCT) scans.[63,64]

Current evidence suggests that CAC, particularly general grading of CAC volume, can be feasibly and reliably assessed using visual or software quantitative analysis methods on LDCT for LCS, which is reinforced by the fact that CAC is one of the most common incidental findings on LDCT for LCS.[63,66,69,74–79] Simultaneously, some evidence suggests that using LDCT from LCS to assess CAC and specifically for the assessment of Agatston calcium scoring may be less accurate.[63] There is also substantial variability in CAC detection on LDCT scans for LCS.[55,67,68,80] Therefore, while using LDCT for LCS to evaluate CAD and CAC is possible, there is no consensus regarding specific approaches or guidelines for using LDCT images for CVD risk assessment.[63,64] Technological innovation utilizing machine learning and artificial intelligence has been proposed as a tool to help diagnose CAC on LDCT for LCS; however, more research is needed to determine the evidence of effectiveness and ensure that the tools are both ethical and equitable.[6,64,71,81–83]

While there is potential benefit in using LDCT for LCS to diagnose CAD and CAC and facilitate earlier clinical intervention, it is important to avoid unnecessary workup – particularly when diagnosis does not necessarily engender clinical action or intervention.[66,69,74] For instance, the Nederlands-Leuvens Longkanker Screenings Onderzoek (NELSON) study found that only 1 percent of incidental findings had significant clinical implications and current data is unclear regarding whether knowledge of the presence of CAC on LDCT for LCS translates to intervention or decreased CV mortality.[70,80] Ultimately, further studies are needed to determine whether CAC could enhance uptake and adherence to primary prevention strategies.[67,70]

Finally, it is important to note that most studies of LDCT for LCS lack diversity, thereby limiting generalizability of the findings to marginalized groups who face higher incidence of lung cancer, lower rates of screening and treatment, more advanced lung cancer disease at diagnosis, and higher lung cancer mortality.[38,84–91] Much of the evidence for LDCT comes primarily from two large clinical trials: The National Lung Screening Trial (NLST) and NELSON; however, 89.6 percent of participants in the NLST were White and of higher socioeconomic status than the general population, while the NELSON study did not report these demographic factors.[38,92–95]

Risks of LDCT: overdiagnosis, false positives, psychological harm, etc.

Although there is strong evidence supporting the use of LDCT for LCS in high-risk groups, it is important to acknowledge that potential psychological harms, overdiagnosis, false positives, and consequent unnecessary treatments and health care costs remain challenges.[11,25,96–99] Overdiagnosis occurs when malignancies that would have remained asymptomatic or progressed too slowly to impact a patient's health are discovered, whereas false positives occur when the LDCT picks up an abnormal finding (e.g., cyst, calcification), but follow-up scans or inquiry are unconcerning.[98–101] Both overdiagnosis and false positives are risks associated with LDCT for LCS that can have negative psychological impacts (e.g., increased anxiety and stress), result in unnecessary diagnostic procedures (e.g., follow-up imaging, biopsies), overtreatment (e.g., surgery, radiation, chemotherapy), and extended patient monitoring.[97,100,102] There is some evidence that false-positives and misdiagnosis are more common among people who are screened using LDCT than x-ray.[12,97] However, there is also evidence that false positive and misdiagnosis rates may be reduced by factors like extending the length of post-screening follow-up, assessing the volume doubling time of detected nodules, and implementing Lung Imaging Reporting and Data System (Lung-RADS) criteria.[9,13,100,103,104] Lung-RADS is a classification system to aid interpretation of findings in LDCT for LCS and standardize follow-up and management decisions. There is no consensus on the optimal cut-off size for nodules classified as positive.[9,10]

Psychological harms like anxiety and distress are commonly associated with cancer screening and LDCT for LCS is no different.[105] False-positive results, overdiagnosis and detection of incidental findings in asymptomatic people are risks that can reduce screening participation.[106] Short-term adverse psychological burden has been reported, particularly after a false-positive result, but this was found to diminish over time.[107–109] Multiple reviews have shown that are no long-term psychological harms from screening.[12,104] Also, there are interventions which have been regularly shown to reduce psychosocial burden in cancer screening including patient-centered communication, psychological preparation for different types of outcome, the use of decision aids in shared decision making (SDM), and multi-faceted interventions incorporating emotional support and patient education can reduce negative experiences.[80,105,110,111] Finally, evidence suggests rates of false positives and overdiagnosis of lung cancer using LDCT are not very different from the overdiagnosis rate of breast cancer, and therefore might be reasonable.[62]

General Lung Cancer Screening Rates

Despite the strong evidence that LDCT is effective for LCS, support from professional organizations and advocacy groups, and increased prevalence of LCS programs (e.g., in community, cancer centers, academic health systems, and Veterans Health Care Administration (VHA)), actual rates of screening remain very low.[20,21] A 2024 study found that roughly 12.7 million adults were eligible for lung cancer screening with LDCT, but only 18.3 percent were screened.[22] This mirrors studies from 2017, 2020, and 2022 that found similarly low screening rates at 14.4 percent, 6.5 percent, and 18.1 percent respectively.[17–19] Importantly, there is significant state to state variability in screening rates -- Florida has a 18.1 percent screening rate, whereas Nevada is

much lower at 6.5 percent.[20,27,39,112] In contrast, one study found county-level breast, cervical, and colorectal cancer screening rates ranging from 39.8 to 89.7 percent.[113] Another study found that among those eligible for LCS, breast and colorectal cancer screening rates were nearly 4 times higher than the LCS rates.[114]

Disparities in Lung Cancer Screening

Lung cancer screening is one of the most observed topics in the health disparities literature.[91] Evidence of disparities in LCDT use for LCS are notable among racial and ethnic minoritized adults, uninsured individuals, and residents of specific regions.[21,38,91,115–118] Evidence also suggests that education level, income, and veteran status also impact lung cancer screening decisions and rates.[21,38,91,115–118] A number of studies and systematic reviews found that Black or Hispanic adults had lower rates of LCS than White adults.[38,116–119] However, the most recent data shows that Native American people have some of the lowest screening rates (14 percent) compared to Black people and White people (20 and 18 percent respectively).[23]

Access to LDCT is a major factor in screening rates, and lack of access is especially pronounced in rural and socioeconomically disadvantaged areas and populations.[120–123] One study found that unscreened patients had a lower annual household income than those who were screened.[116] Individuals with low socioeconomic status also face financial, social, and geographic barriers to accessing LCS and essential follow-up.[124] LCS utilization is also influenced by health insurance access, coverage, and costs as evidence by the fact that individuals with higher total out-of-pocket medical costs are less likely to adhere to annual LCS.[125,126] Similarly, there is evidence that a greater proportion of screened non-Hispanic Black respondents were of Medicare age and gaining access to Medicare coverage increased LCS in screening-eligible men.[127,128]

Patterns of LCS accessibility and utilization vary with geographical factors like total distance from screening facilities, regional differences tied to historical trends and priorities, and rural-urban environment differences that impact resources. One study found that five percent of the population eligible for LDCT does not have access to screening facilities within 40 miles and this is markedly higher among individuals living in micropolitan and rural counties at 17.1 percent and 24.5 percent.[123] Evidence generally indicates that a larger percentage of the rural population lacks access; however, some studies found that urban residents were less likely to be screened and less likely to be aware of screening.[38,123,129–132] LDCT screening rates also vary widely across states.[119,133] Several southern states with a high lung-cancer burden (e.g., Mississippi, West Virginia, and Arkansas) have relatively low rates of screening, whereas several northeastern states with lower lung cancer burden (e.g., Massachusetts, Vermont, and New Hampshire) had the some of the highest rates of LDCT screening. Kentucky is a notable exception as they have high lung cancer mortality and also one of the highest screening rates.[119,133]

Finally, veteran status is associated with increased odds of screening.[131] Veterans have higher smoking rates than their nonveteran peers, but there is also evidence that efforts by the Veterans Health Administration (VHA) hospitals have resulted in good LCS uptake with more than half of eligible VHA patients agree to undergo screening at eight demonstrations sites between 2013 and 2015.[134,135] Notably, VA-Partnerships to Increase Access to Lung Screening (VA-PALS), a multidisciplinary collaboration between clinicians and computer scientists within and outside the VA to increase access to high quality LCS, might contribute to higher rates of screening among vets.[131,136]

BARRIERS TO LDCT LCS UTILIZATION AND EFFORTS TO ADDRESS THEM

The most common barriers to utilization of LDCT for LCS are patient and clinician knowledge, perceived high false-positive rate leading to unnecessary procedures, patient refusal, time constraints, lack of transportation, concerns about cost or lack of insurance coverage, and difficulty using the electronic medical record (EMR) to determine and notify clinicians of eligible patients.[137] These barriers fall into two conceptual groups: (1) knowledge, attitudes, and beliefs; and (2) structural barriers to access.

Clinician and patient knowledge, attitudes, and beliefs

There is evidence that physicians support LDCT for LCS and that they believe the benefits outweigh the potential harms for high-risk patients.[138] Yet evidence also suggests that physicians' lack of knowledge about eligibility, screening guidelines, and CMS insurance coverage is an obstacle to referral of LDCT.[38,88,116,138–146] Several studies illustrate the mistaken belief among physicians that the USPSTF recommends screening with chest x-ray.[139,140,142] There is also evidence that many clinicians struggle to accurately identify all CMS eligibility criteria or correctly state the current guidelines.[21,137,138,147] One study found that the majority of physicians were unsure whether Medicare/Medicaid covered LDCT LCS, despite the fact that CMS had already issued their coverage determination.[138] This is concerning since a majority of physicians in that study also reported that they would recommend LDCT screening for high-risk patients if cost were not an issue.[138]

There is also evidence that clinicians' perceived patient barriers (e.g., lack of awareness, stress, anxiety, cost, and lack of insurance coverage) and concern about the potential for false positives are significant obstacles to lung cancer screening referrals.[138,140–144,147,148] Clinician knowledge levels may also be impacted by setting. One study found that academic-based clinicians achieved similar knowledge scores to community-based clinicians, both of which were significantly higher than the knowledge scores of health care professionals in safety net-based settings.[137] Similarly, another study found that almost all physicians reported that a computed tomography machine was available at a facility within 20 minutes of their practice, but nearly half were unsure of whether LDCT screening was offered at those facilities.[138] Finally, controlling for clinician characteristics (hospital affiliation, specialty, title, employment) and CMS eligibility provider knowledge scores, a higher provider knowledge score was associated with a higher likelihood of ordering a LDCT scan.[137]

Lack of knowledge or awareness about LDCT for LCS is also commonly reported by patients.[149–153] Multiple studies found that most eligible smokers had little or no knowledge about lung cancer screening and had never had a health care professional recommend it to them.[38,144,152,154,155] This is important as lack of knowledge can contribute to feelings of fear, fatalism, and stigma, which are also reported by patients as barriers to utilizing LDCT for LCS.[144,152,153,155–157] Findings from one review show that screening attendance is affected by fear of both diagnosis and screening procedure.[158] Similarly, one study found that the primary barrier to returning for subsequent annual screenings was receiving a negative or false-positive screening result.[151] Moreover, a generational history of discrimination and mistrust contributes to perceptions of stigma and challenges with patient–clinician communication.[39] As a result, underrepresented racial/ethnic populations and individuals with low socioeconomic status exhibit greater feelings of fatalism, nihilism, and futility associated with medical intervention, which may reduce pursuit of lung cancer screening.[155–157,159] Furthermore, there is some evidence of differences in total knowledge scores associated with race, with White participants having slightly higher total knowledge about screening when compared to Black participants.[148] In a separate study, Latinx patients were more likely to believe that lung cancer can be prevented, were less worried about developing lung cancer, and had a greater

willingness to be screened when educated about screening when compared with non-Latinx patients.[160]

Intervention to improve knowledge and awareness: Education, public awareness, and shared-decision-making

There is some evidence that educational efforts can increase both clinician and patient knowledge and awareness.[112,161–164] Some studies have demonstrated that group based learning, targeted education programs, and educational lectures can increase clinician knowledge about LCS, improve their ability to identify eligible patients, and increase referrals to LDCT; however, most interventions to increase LDCT LSC rates have targeted patient education with SDM.[112,161,162,164] This is likely because SDM counseling is required for reimbursement and recommended by federal agencies and national specialty societies to help patients in making informed decisions about LCS.[165,166]

There is significant variability in studies of and approaches to SDM for LCS; however, evidence from multiple reviews and studies demonstrate that decision aids, tools, and processes for SDM improve patient knowledge, reduce decisional conflict and regret, show acceptability to patients and clinicians, and increase LCS uptake and adherence.[96,110,167–172] Moreover, when effectively tailored to populations at higher risk for lung cancer, SDM can further promote health equity.[172,173] At the same time screening rates remain low and many clinicians cite major barriers to utilizing SDM, including time constraints, competing clinical demands and priorities, limited awareness about LCS guidelines, lack of skilled training in SDM, and insufficient resources to implement SDM.[164,174–176] One study found that clinicians were concerned about the feasibility of integrating yet another recommendation into routine practice, let alone the capacity to provide the high-volume, high-quality lung cancer screening and treatment centers required to support screening programs.[140] There are also concerns that SDM conversations are often too brief, prioritize exchanging information over patient preferences, focus on benefits over harms, and lack sufficient use of decision aids.[176,177] This underscores the need to both explore alternative methods of SDM which can minimize hands-on clinician time and expand beyond a sole focus on education interventions to incorporate multilevel targets when designing LCS interventions.[110,164]

Proposed approaches include integrating SDM and telehealth for LCS, prediction-augmented SDM tools, developing adaptable SDM training programs, developing novel SDM decision aids and tools, and establishing key SDM process and training quality measures.[172,178] For example, one study found that conducting SDM over the telephone could be a way to address logistical barriers, improve patient knowledge, and reduce fatalistic beliefs and distrust in the medical system.[179] Implementation should consider feasibility and that delivery should include patient-facing print, web, in-person, and video options.[96] Moreover SDM content and presentation methods should be developed collaboratively with screening-eligible adults.[180]

Structural Barriers: Time Constraints, Insurance Coverage, and Electronic Health Records (EHR)

Even when patients and clinicians are well informed about the risks and benefits of LDCT there are several structural barriers that may prevent them from pursuing or accessing LDCT. For instance, the EHR can be a useful tool to cue physicians to patients who are eligible for LDCT; however, that requires that the EHR contains detailed and accurate smoking history calculation and age.[21] Eligible individuals may be missed if they do not have a clinical encounter or if the EHR fails to capture and retain accurate cumulative pack-year calculations.[181] For example, one cross-sectional study found that imprecise smoking history data in the EHR resulted in identifying only 30 percent of potentially LCS eligible study respondents when searching for screen-eligible beneficiaries for

LCS.[182] Reliance on EHRs for referrals is complicated by the patchwork nature of the current health care system in the U.S. and by the underuse of health care services and cancer screening among people who smoke.[183,184]

Many physicians also referenced patient barriers like insurance coverage and cost as rational for why they did not bring up or recommend LDCT for LCS with the patients who might be eligible.[140] One study found that the most reported barriers to ordering screening included prior authorization requirements, lack of insurance coverage, and coverage denials.[175] Since 2015, LCS with LDCT has been covered under Medicaid; however, to qualify for reimbursement several criteria, including SDM counseling, must be met. This creates two interconnected barriers. First, the SDM requirement has been interpreted by some to be a time-consuming barrier to uptake.[179,185] Second, individual state-based decision-making rules and rejection of Medicaid expansion have limited access to LCS using LDCT, and in some cases, continues to leave eligible LCS candidates without a route to screening.[19,39,186,187] There is evidence that screening implementation is higher among individuals with insurance compared with uninsured subjects.[188] Yet, underrepresented racial/ethnic populations are more likely to be uninsured or ineligible because of foreign-born nativity or citizenship status.[39] More than half of those who qualify for lung cancer screening on the basis of USPSTF recommendations are estimated to have Medicaid or be uninsured.[146]

Structural barriers like lack of transportation, cost of screening, and time constraints (e.g., inability to get time off of work, inability to find child care, and other pressing issues) also limit access or a patient's reported willingness and/or ability to pursue LDCT for LCS.[144,149–152,158] For example, one study found decreased intention to screen when patients were required to pay for the test.[157]

Structural Interventions: Mobile LDCT, digital interventions, and patient navigation

Logistical barriers to access are some of the most reported by patients, particularly by marginalized individuals who often have higher rates of lung cancer and worse lung cancer mortality. The two primary approaches that have been used to address logistical barriers are those that either focus on bringing LDCT to underserved areas (e.g., mobile LDCT and telehealth) or on facilitating patient navigation (e.g., scheduling support, reminders, transportation).

For instance, mobile screening services might offer a potential solution to narrow healthcare disparities for marginalized populations.[125,189] There are some studies that show that mobile LDCT LCS platforms can lead to higher rates of LCS and early lung cancer detection, particularly in underserved populations. However, more research is needed to confirm the evidence and determine scalability.[190] Similarly, digital interventions, particularly decision aids and telehealth, have shown promise in improving knowledge and the quality of decision-making around LCS, but there are very few studies and the effects are small.[191] Ultimately, further research is needed to determine the evidence of effectiveness, feasibility, and scalability of mobile LDCT, digital decision aids, and telehealth interventions.

There is also evidence that centralized programs are more effective regarding screening rates, adherence to guidelines, and follow-up care, than decentralized programs.[192–195] However, centralized programs require considerably more investment and resources.[178,196] There is also substantial variation in practices utilized across centralized LCS program models, including the specific structures and practices that enhance LCS quality and effectiveness, which has not been sufficiently explored.[119,192,193,195,196] Often centralized programs employ processes that improve screening among underserved populations, including clinical reminders to identify eligible patients, providing educational materials, addressing barriers to accessing care such as insurance coverage and transportation, and patient navigation.[196,197] There is also some evidence that patient navigation

practices, including scheduling support, reminders, and transportation may improve LCS uptake and adherence, particularly in vulnerable populations.[198–201] Furthermore, the few interventions addressing social determinants of health in LCS have favorably resulted in increased screening rates.[202] While more evidence is still needed, it is likely that effective, equitable screening requires addressing barriers along several steps of the LCS continuum.[195,203]

CURRENT AMA POLICY

AMA Policy, H-185.936 "Lung Cancer Screening to be Considered Standard Care" addresses LDCT for LCS. It highlights the importance of insurance coverage, improving access, and the need to promote education and awareness about LDCT for LCS to patients and clinicians.

CONCLUSION

Lung cancer has significant health and economic impacts in the U.S., particularly since it is often diagnosed late when prognosis is poor.[1–3] Moreover, these effects are often more prevalent among marginalized individuals. However, there is strong evidence that LDCT LCS can result in earlier diagnosis and better health outcomes as well as emerging evidence of the potential to use LDCT for LCS to diagnosis CAC.[4–12] Despite the benefits of LDCT for LCS, rates remain low.[17–22] Most of the current interventions to improve LDCT LCS focus on either: (1) improving education or (2) addressing structural barriers. There is some evidence that education improves knowledge and awareness for both patients and clinicians, particularly through SDM. However, even with increased use of SDM, screening rates remain low, suggesting greater emphasis should be put on evaluating ways to improve SDM or on interventions that address structural barriers. Early efforts to bring LDCT to underserved areas (e.g., mobile LDCT and telehealth) or to facilitate patient navigation (e.g., scheduling support, reminders, transportation) are promising but there is a clear need for more research to confirm the evidence of effectiveness, feasibility, and scalability.

RECOMMENDATIONS

Your Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 404-A-25 and the remainder of the report be filed.

That Policy H-185.936 "Lung Cancer Screening to be Considered Standard Care," be amended by addition to read as follows:

1. Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.
2. Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
3. Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.
4. Our AMA, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR), will create and share educational resources and training to help

physicians efficiently discuss and document low-dose computed tomography (LDCT) lung cancer screening during shared decision-making visits for high-risk populations.

5. Our AMA will promote physician education and awareness regarding the value of low-dose CT in detecting lung cancer, and will encourage education, technological innovation, and continued research around the detection of coronary artery calcification on low-dose CT performed as a part of a lung cancer screening program.
6. Our AMA will support efforts by key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to research interventions to improve access to and utilization of lung cancer screening with low-dose CT scans in high-risk patients.

(Modify Current HOD Policy)

Fiscal note: Minimal

APPENDIX

Table 1. Lung Cancer Screening Guidelines

Organization (Year)	**Age**	**Pack years**	**Other**
American Academy of Thoracic Surgeons (2012)[204]	55-79	30	Currently smoke or quit <15 years ago
US Preventive Services Task Force – B Recommendation (2021)[166]	50-80	20	Currently smoke or quit <15 years ago
American Academy of Family Physicians (2021)[205]	50-80	20	Currently smoke or quit <15 years ago
American Cancer Society (2023)[206]	50-80	20	Currently smoke or previously smoked
American College of Chest Physicians (2021)[207]*	55-77	30	Currently smoke or quit <15 years ago
American College of Chest Physicians (2021)[207]**	50-80	20	Currently smoke or quit <15 years ago
National Comprehensive Cancer Network (2024)[208]	50 ≥	20	History of smoking
Medicare & Medicaid Coverage[186]	50-77	20	Currently smoke or quit <15 years ago

*Offered with a strong recommendation
**Offered with a weak recommendation

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-A-26

Subject: Removing Artificial Turf in Schools, Parks, and Public Places

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 408-A-25, "Removing Artificial Turf in Schools, Parks and Public Places," was referred for study and asked the following:

> That our American Medical Association (AMA) recommend replacing artificial turf with natural, drought-tolerant and hardiness zone appropriate turfgrass in parks, sports fields and lawns when it is to be replaced; and be it further
>
> That our AMA support natural, drought-tolerant and hardiness zone appropriate turfgrass as the preferred choice on sports fields or lawns, in all public and private schools and colleges, as well as in city parks.

This report provides a summary of the available evidence on the positive and negative health impacts of artificial turf fields, the current landscape of legislative activity to limit artificial turf, and available evidence for disproportionate impacts on specific populations.

METHODS

English language reports were selected from searches of PubMed and Google Scholar databases using the search terms: "artificial turf" AND "health impacts", "artificial turf" AND "injury," and "artificial turf" AND "accessibility." Legal websites, such as LexisNexis, and Google were utilized to search for state and local legislation on artificial turf. Search terms included "[State name] ban or regulations on artificial turf" and "cities or counties in [State name] that have bans or regulations on artificial turf". Additional articles and sources were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the U.S. Environmental Protection Agency, and applicable professional and advocacy organizations were reviewed for relevant information.

BACKGROUND

Artificial turf is made by heating plastic resin (generally polyethylene and polypropylene) so it can be reshaped into a yarn-like substance to produce grass-like threads that sit on several layers that provide cushioning. Artificial turf was first introduced in the 1960s and was originally intended to provide cushioned recreational surfaces for urban schools that did not have natural grass play areas or found them difficult to maintain.[1] Artificial turf has gone through several technological phases since then. First generation artificial turf, commonly known as AstroTurf, gained notoriety when it was installed in the Houston Astrodome in 1966.[1] AstroTurf was composed of short, stiff nylon fibers layered over a compacted soil base, sometimes with a closed-cell foam cushion added beneath the carpet.

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AstroTurf had significant technical limitations, aesthetic shortcomings, and was criticized for its abrasive textures, resulting in concerns about injuries. The second generation of artificial turf was developed in the late 1970s and included a shock-absorbing pad beneath the first-generation carpet with longer fibers compared to the first-generation turf. Additionally, in this evolution of artificial turf, infill materials were added, such as silica sand, which filled the spaces between the turf fibers, allowing them to stand upright. While the introduction of infill materials improved shock absorption, it caused painful abrasion injuries.[1,2]

For the current, or third generation, of artificial or synthetic turf, introduced in the late 1990s, the composition of artificial threads changed from polypropylene to polyethylene which increased the fiber length and decreased the risk of skin abrasion.[1] The artificial grass sits on several layers, including an infill layer made of rubber (generally recycled tire crumb), coconut fibers, cork, nutshells and sand, a backing layer to which the blades are sewn, a drainage layer, and sometimes additional padding layers.[2] Technological advances within the last five years in artificial turf aim to address existing issues with heat retention, environmental concerns, and injury risk, with the development of environmentally friendly materials, improved drainage, recyclability, and antimicrobial treatments, but these are very recent advances and most installations of artificial turf are using third generation synthetic turf as described above.[1,2]

Since its introduction in the 1960s, the use of artificial turf across the country has grown, with nearly 19,000 turf fields currently estimated to be in use across North America.[3] Proponents of artificial turf argue that it can be used in all weather conditions, it provides multi-use opportunities, that it can save water, reduce the need for toxic pesticides and fertilizers, uses recycled materials (i.e., rubber tires), and is less expensive.[4] Despite these purported advantages, many communities are concerned about the potential health impacts of artificial turf, leading some cities to ban them or reject installation of new fields.[5] The following summarizes the known health risks and environmental concerns of artificial turf versus natural turf as well as an overview of legislative activity on this subject. For easy reference, a comparison table summarizing the advantages and disadvantages between artificial turf and natural turf grass is provided in Table 1.

DISCUSSION

Environmental Health Concerns

Many chemicals found in synthetic turf fields have known health risks, including benzene, arsenic, volatile organic compounds, phthalates, and per- and polyfluoroalkyl substances (PFAS). A 2016 Environmental Protection Agency (EPA) literature review on recycled tire crumb used in artificial turf identified 350 unique chemical compounds, some of which have known adverse health impacts.[6] This EPA report stated that studies had not shown an elevated health risk from playing on artificial turf fields but acknowledged study limitations that did not allow for a comprehensive evaluation.[6] A 2024 follow-up report by the EPA, Centers for Disease Control and Prevention (CDC), and the Agency for Toxic Substances and Disease Registry (ATSDR) included pre- and post-activity biomonitoring data on polycyclic aromatic hydrocarbon (PAH) concentrations in approximately 160 study participants. PAHs represent a group of chemicals naturally found in fossil fuel-based products.[7] The 2024 EPA/CDC/ATSDR study did not report any significant differences in PAH concentrations based on turf type (i.e., synthetic versus natural).[7] This indicates that while there may be chemicals present in the artificial turf, that does not necessarily equate to increased exposure risk for users of artificial turf fields. However, beyond point of contact exposure, artificial turf has the potential to pollute local water systems, such as groundwater and nearby streams and water bodies.[3,8,9]

Artificial turf is also of concern as plastics break down into smaller pieces called microplastics. Microplastics are pieces of plastic that range in size but are less than 5 millimeters.[10] Microplastics have been found throughout the human body, including a recent finding of microplastics in the olfactory bulb of the brain.[11,12] While research on the health impacts of microplastics themselves in our body is still nascent, recent research found a four-fold increase in the risk of poor cardiovascular outcomes in patients with microplastics present in their carotid artery plaque.[13] Microplastics can also be viewed as "trojan horses" as they carry with them a complex array of chemicals which separate from the plastic and spread throughout our bodies via the circulatory system.[14] While health and safety information are lacking for most chemicals in plastic, at least four major categories of chemicals found in plastics have been more extensively studied in terms of health impacts. These include phthalates, bisphenols, PFAS, and flame-retardant additives.[15] The effects of these chemical additives are known to affect nearly every organ system in the body of people of all ages, but particularly young children.[16] More detailed information on the health and environmental impacts of plastics and microplastics can be found in the AMA Council on Science and Public Health Report, *Plastic Pollution Reduction*, adopted at the AMA House of Delegates 2025 Interim meeting.[17]

In comparison, the primary environmental concerns for natural turf fields include exposure to and environmental contamination from pesticides and water usage. Pesticide pollution negatively impacts water, soil, and the surrounding environment and has negative health impacts, particularly for workers regularly exposed via occupational applications (e.g., groundskeepers, landscapers, and farm workers).[18] Depending on the frequency and level of exposure, pesticides can result in both acute and long-term health consequences, including cancer, neurological disorders, and endocrine disruptions.[19] Pesticide exposure can also increase the incidence of respiratory issues and neurodegenerative diseases.[19] However, agricultural uses account for nearly 90 percent of total pesticide applications in the U.S. and thus the contribution of pesticides from use on recreational fields likely constitutes a relatively small portion of human and environmental exposure.[20]

In terms of water usage, natural grass turf is water-intensive and depending on the size of the field and local climate, may require substantial water resources per year. On the other hand, natural grass helps reduce runoff and mitigate flooding as it both stores water and slows down groundwater infiltration, although fields can flood with heavy rainfall.[18] Flooding has been demonstrated to be a challenge for artificial turf fields as well, sometimes requiring intensive repairs or total replacement after a flood event.[3] In a risk-benefit analysis of natural grass versus artificial turf, it was noted that the creation of the plastic used in artificial turf is so water intensive and because artificial turf may require water to cool it during hot weather, the purported water savings over the course of its useful life might be overstated.[2] Natural grass fields also offer several environmental benefits, including reducing surface temperatures, supporting biodiversity (depending on pesticide usage), reducing soil erosion, and acting as a carbon sink.[18]

Another important environmental consideration in the debate between artificial and natural turf is the disposal of artificial turf at the end of its useful life. One factor that proponents of third generation artificial turf market is that the infill uses recycled rubber tire crumb.[4] There are many challenges with disposing of rubber tire crumb, including that it contains a range of metals, semivolatile organic compounds, volatile organic compounds and bacteria that can leach into surrounding soil and water, contaminating local ecosystems.[21] Additionally, large concentrations of rubber tires in landfills pose a fire hazard as they are highly flammable and create toxic smoke when burned.[21] However, while artificial turf has been positively marketed as a way to help with the issue of rubber tire waste, the turf itself has a limited lifespan and poses its own waste management challenges. Artificial turf has an average life span of eight to ten years and disposal of turf is difficult, as it cannot be easily recycled.[22] Communities have struggled to find ways to

dispose of it, as in some cases municipal collection systems will not accept it and existing methods create additional environmental challenges.[2,22]

Heat-related Illness

In addition to the chemical exposure risk, artificial turf fields also retain more heat than natural grass as the synthetic materials absorb solar energy, creating localized 'heat islands.'[23] Artificial turf fields have been documented to reach temperatures between 160- 200 degrees Fahrenheit on warm, sunny days (over 90 degrees).[23] These extreme temperatures increase the risk of skin burns (first to third degree) and heat-related illness, such as heat stress, heat exhaustion, and heat stroke. These issues are increasingly of concern with warmer temperatures caused by climate change and have important implications for urban climate resilience. For example, the average number of heat waves experienced by U.S urban areas has increased from two per year in the 1960s to six per year in the 2010s.[24] Higher temperatures have resulted in higher rates of heat-related illness, particularly for young athletes; the prevalence of heat illnesses and heat-related deaths occurring in organized sports has increased among high school athletes.[18]

Injury Risk

Many different factors influence the risk of sports injury, including the type of activity, level of competition, weather conditions, individual characteristics, and playing surface. Even among synthetic turf fields, there is a range of turf surfaces and there have been changes to synthetic turf products over time, which make attribution of risk challenging. In terms of comparing lower extremity injury risk between natural and synthetic turf fields, a systematic review found similar overall injury rates in a majority of articles evaluating newer synthetic turf fields, but football players, particularly those at high levels of competition, were more likely to sustain a knee injury on artificial turf than on natural grass.[25] Another systematic review comparing injury rates between female and male soccer players on artificial turf versus natural turf found female soccer players had a significantly higher risk of anterior cruciate ligament injuries on artificial turf compared to natural turf.[26] Concerns over increased risk of knee injuries led the National Football League Players Association to call for the elimination of artificial turf fields in 2023.[27]

Other common injuries for competitive contact sports include head injuries and concussions. A systematic review on comparative risk of these types of injuries based on the type of playing field found rate ratios for head injury and concussion were less on artificial turf compared to natural grass fields, though the analysis was based on limited publications.[28] In subgroup analyses by sport type, effects were significant among rugby and American football but not significant for soccer.[28] These mixed findings indicate that the potential risk of sport injuries on artificial turf versus natural turf is complicated by many factors, including the type of sport, the type of injury studied, and the age (and likely maintenance) of the fields.

User Preferences and Recreational Opportunities

Anecdotally, artificial turf fields are believed to promote more physical activity as they provide consistent, year-around, and needed recreational fields to meet the needs of many competing community interests. Additionally, media accounts of local decision-making processes regarding the installation of turf fields reflect a high demand for recreational playing fields in communities with high levels of youth and adult sports leagues, hence why the durability and year-round ability to play on artificial turf fields is a compelling advantage for these communities.[3] However, research among a broad array of park users, including athletes, have demonstrated an overall preference for natural turf fields over artificial turf, with respondents to surveys on the issue indicating

environmental, aesthetic, heat, and perceived injury risk concerns associated with artificial turf in comparison to natural turf.[29–31]

Equity considerations

While underserved urban areas may have a lack of greenspace available for recreational uses, installing artificial turf in these same areas may inadvertently increase the urban heat island effect. Urban heat islands are a phenomenon where urban areas experience significantly warmer temperatures as compared to surrounding suburban and rural areas, due to a lack of greenspace, a higher proportion of concrete and asphalt surfaces, and radiative heating from buildings and cars.[32] Urban heat islands disproportionally impact communities that have been historically marginalized, especially Black communities, due to historical discriminatory practices like redlining and racialized zoning.[33] Urban heat islands can be exacerbated by artificial turf fields as they also retain and radiate heat.[2,23] Thus, installing artificial turf in communities that already are at greater risk of heat-related illnesses from exposure to urban heat may exacerbate existing inequities.

During testimony at the reference committee hearing on Resolution 408-A-25, delegates raised the question of whether the removal of artificial turf fields would have negative repercussions for users and athletes with disabilities, in particular those who use wheelchairs. There was no peer-reviewed evidence on differences in accessibility for users with disabilities between artificial turf and natural turf fields. While it is assumed artificial turf can provide good accessibility for those using wheelchairs due to its relatively smooth and even surface, it is critical that it meet the Americans with Disabilities Act requirements, be well installed, and consistently maintained to improve accessibility for all users.[34]

LEGISLATION

A few states have passed legislation that bans or restricts the installation of artificial turf and many of them are explicitly focused on banning artificial turf that contains PFAS chemicals. Colorado, for example, beginning January 1, 2026, bans the installation of artificial turf "that contains intentionally added PFAS chemicals" though it does not prohibit maintaining existing artificial turf that is installed before January 1, 2026.[35] Similarly, as of July 1, 2024, Vermont banned manufacturers from selling or distributing artificial turfs that have PFAS intentionally added or entered the product from the manufacturing or processing of the product that the manufacturer knew or should have been aware about.[36] As of January 1, 2025, Minnesota prohibited PFAS in a variety of products.[37] While artificial turf is not explicitly mentioned in that state statute, the Minnesota Pollution Control Agency noted that artificial turf falls under one of the explicitly mentioned categories.[38] Nevada has required "nonfunctional turf" to be removed before December 31, 2026.[39] Beginning January 1, 2029, artificial turf that contains intentionally added PFAS is not allowed to be sold in Rhode Island.[40] Maryland has required the Department of the Environment, in collaboration with several other groups and representatives, to conduct a study on the synthetic turf industry and report its findings to committees within the General Assembly by July 1, 2026.[41] Based on that report and the Department's findings, regulations and restrictions on artificial turf may be adopted.

In the absence of state-wide regulations, some cities have passed ordinances or rules regulating artificial turf.[42–45] Regulations can include a complete ban on the installation of new artificial turf, a ban on artificial turf in only some areas or lot types, requiring existing artificial turf to be replaced with natural grass by a certain year or once repairs cost a certain amount, or be a temporary ban. Temporary bans, typically referred to as moratoriums, often act as a pause on the installation of artificial turf so the community can further study the effects and possible alternatives to artificial

turf. An example of this was a proposed in Maine, but it was not enacted.[46] In locations without legislative activity, municipalities are educating residents about potential health risks. For example, the Board of Health in Amherst town, Massachusetts created advisements related to the health risks of artificial turf and hosted webinars about the issue even though they have no law or ordinance regulating the use or installation of artificial turf.[47,48] Table 2 highlights the types of regulations related to artificial turf, but this should not be considered a comprehensive list.

EXISTING AMA POLICY

AMA does not have existing policy on artificial turf but does have policy on the health harms of microplastics, supporting the use of ecologically sustainable products, as well as several policies on a few chemical additives common in artificial turf, including PFAS, and phthalates.[49–52] Additionally, AMA policy supports the creation and maintenance of existing public land and outdoor spaces for recreation and policy that aims to reduce the risk of concussion and other injuries in youth sports.[53,54]

CONCLUSION

While artificial turf has the potential to provide more reliable and consistent recreational fields for year-round activities, there are risks and disadvantages that communities should consider prior to its installation. These disadvantages include high costs of installation, increased human and environmental exposure to a wide array of chemicals, heat absorption and increased risk of heat-related illnesses for users during the summer, injury risks, and disposal challenges at the end of its useful life. While artificial turf may ease mobility constraints compared to natural grass, true accessibility remains broader in scope.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 408-A-25, and the remainder of the report be filed.

1. The American Medical Association (AMA) recommends well maintained, natural, drought-tolerant and hardiness zone appropriate turfgrass, with the use of integrated pest management to reduce potential chemical exposures, as the preferred choice on sports fields or lawns, in public and private schools and colleges, as well as in city parks.

2. Our AMA recommends municipalities conduct comprehensive risk-benefit analyses when deciding whether to replace natural turfgrass with artificial turf (or vice versa) to best meet the needs and concerns of their communities, including those with accessibility concerns.

3. The AMA encourages more research to address evidence gaps on the potential health risks of artificial turf fields. In particular, more research is needed on the release of chemicals from artificial turf, the level of exposure to turf users, and potential health impacts, as well as the differences in risk from heat-related illnesses and physical injuries on artificial turf versus natural turf.

(New HOD Policy)

Fiscal note: Minimal

Table 1. Natural Grass Fields vs. Synthetic Turf - A Summary of Advantages and Disadvantages

Natural Grass	Artificial Turf
Environmental impacts	
Advantages • Climate benefits. Natural grass contributes to carbon sequestration, reduces stormwater surface runoff, and helps maintain a healthier ecosystem by supplying oxygen, filtering stormwater, and absorbing heat. • No waste. Natural grass fields do not have an end of life and, therefore, do not create waste that must be recycled or disposed of. **Disadvantages** • Chemical Exposures. Natural grass athletic fields often require the use of pesticides to ensure playability. • Water Dependency. Natural grass athletic fields require consistent irrigation, particularly in drier climates.	**Advantages** • Water Conservation. Although water is used occasionally for cooling and cleaning synthetic turf, limited evidence is available for quantifying the amount of water used for these purposes. **Disadvantages** • Chemical Exposures. Synthetic turf fields can contain chemicals that may be harmful to human health and the environment. Chemicals can leach from the synthetic components of the turf into local water systems and research shows that some synthetic turf fields contain microplastics and potentially toxic chemicals, such as PFAS chemicals. • Waste. Currently, recyclability of the components of synthetic turf fields at the end of their usable life (~8 to 10 years) is questionable both due to limited information provided by companies that supply and maintain synthetic turf fields and because the complex construction of synthetic turf makes it challenging and costly to recycle. • Drainage. Synthetic turf does not pull water out of soil and release it into the air nor does it filter pollution to protect water quality of nearby waterways like natural grass can.
Maintenance and Costs	
Maintenance. Keeping natural grass up to the highest playing standards requires more consistent upkeep compared to a synthetic turf field. Natural grass requires regular mowing, watering, fertilizing, and pest control, which requires labor and incurs costs. This is especially true in climates that are not conducive to growing and maintaining grass. **Cost-Efficiency for Installation and Renovation**. The installation and renovation	**Maintenance.** Synthetic turf fields typically require less maintenance than natural grass fields as it does not require mowing, watering or fertilizing. Thus, required labor and maintenance costs are typically lower for synthetic turf fields. **Initial Cost.** The initial cost of installing synthetic turf can be relatively high, with costs varying depending on the type and quality of turf chosen. The replacement cost of synthetic turf can also be high.

cost of natural grass is typically lower than that of synthetic turf.	
Accessibility and Playability	
Advantages • Potential for Less Injuries. There are some studies that show that natural grass is a safer playing surface with fewer injuries to players compared to synthetic turf fields, however studies are inconclusive and limited. • Cooler Surface. Natural grass remains cooler than synthetic turf during hot weather, reducing the risk of heat-related injuries and making it more comfortable for athletes. **Disadvantages** • The overuse of a natural grass field can result in uneven and damaged playing surfaces, affecting the quality of gameplay and increasing the risk of injuries to players. Further, rainfall or moisture on natural grass fields can create a slick surface. • Weather Dependency. Use of natural grass fields can be heavily influenced by weather conditions. Fields are typically closed for use due to rain or extreme weather, which can disrupt scheduled events. Fields often cannot be used for several days after a big rainfall because use can significantly damage wet fields. • Limited Hours. Often, natural grass fields are not available for play during winter months because the field needs to "rest." In addition, hours of use must be limited throughout the rest of the year to maintain fields in playable condition.	**Advantages** • Year-Round and Consistent Usage. Synthetic turf fields are typically available for use year-round except when the ground is frozen. Additionally, turf provides more predictable play for athletes such as consistent player footing. • Durability/More Hours of Play. Synthetic turf can withstand heavy use and is less susceptible to wear and tear compared to natural grass. Fields are not susceptible to bald spots or other damage from overuse like natural grass fields, allowing for longer hours of play on synthetic turf field. However, more use can reduce its useful life. • Limited space: Synthetic turf fields are useful in environments with limited recreational fields as they can be used consistently throughout the year. • Permanent Marking. Field lines and markings for multiple sports can be permanently inlaid on synthetic turf fields, eliminating the need for continual re-striping with paint required for natural grass fields. **Disadvantages** • Potentially More Injuries. While more research is needed, data from several studies show that injuries are more prevalent for athletes on synthetic turf compared with natural grass. An increased risk of "turf burn" also increases players' susceptibility to antibiotic-resistant staph infections (i.e., MRSA). • Heat Issues. Synthetic turf can reach significantly greater temperatures than natural grass under the same weather conditions, which can increase the risk of heat-related illnesses for players, create

	uncomfortable play conditions, and result in skin burns if direct contact is made. • Limited Lifespan. Synthetic turf has a lifespan of typically eight to ten years. Lifespan can be impacted by local climate, maintenance, and use. • Movement of Infill. Synthetic turf infill requires proper depth and weight or it can move throughout the seasons, causing bulges and wrinkles in the surface that can be a hazard to players.

Table 2. Examples of artificial turf legislative/regulatory actions

California	A handful of cities in California have banned artificial turf and added restrictions on existing ones. In 2024, Millbrae prohibited the installation of synthetic grass and artificial turf.[43] Additionally, if existing synthetic grass or artificial turf is damaged or destroyed to a prescribed level, it must be replaced with "water-efficient natural landscaping." Similarly, San Marino recently banned installation of synthetic grass and artificial turf in most cases.[55] Exceptions are that the ban does not apply to facilities that are owned and used by schools and rear yards of residences under 100 square feet. Any existing artificial turf or synthetic grass that is damaged to the extent of 35 percent of its replacement cost must be removed and replaced with water-efficient natural landscaping. Additionally, all existing artificial turf, synthetic grass, artificial plants or artificial vegetation must be removed no later than October 31, 2030.
Connecticut	Westport has banned the creation of any new or replacement of playing fields using synthetic infill material (means ambient and cryogenic crumb rubber, coated crumb rubber, ethylene propylene diene monomer granules, and recycled footwear).[56]
Louisiana	In the historic districts of Louisiana, many preservation commissions have prohibited synthetic turf in front yards and have issued removal orders and fines for homeowners that have installed artificial turf without permission.[57]
Massachusetts	In 2022, Boston's mayor directed that no new artificial turfs are to be installed in the city of Boston.[42] Some other cities, such as Wayland and Concord, have passed a temporary ban on installing new artificial turf.[58,59]
New Jersey	The city of Belmar has a list of districts and locations where artificial turf is banned and has requirements that locations must meet before being allowed to install artificial turf.[60] This does not apply to designated sports fields on public property where the installation of artificial turf has been approved by the Borough's Governing Body.
Texas	Murphy city has banned homeowners from installing synthetic turf if it is visible from the street. However, if artificial turf was installed before August 1, 2014, it is not affected by this ban as it was grandfathered in.[44]
Utah	In Salt Lake City, artificial turf is not allowed in "areas that require landscaping" and any artificial turf that was installed before March 5, 2024

	must be removed by September 18, 2025. Previously, as early as 1995, Salt Lake City banned artificial turf in other specific areas.[45]

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REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities

EXECUTIVE SUMMARY

BACKGROUND. Resolution 421-A-25 was referred by the American Medical Association (AMA) House of Delegates (HOD). The resolution asked that our AMA seek a study and report back providing recommendations at the federal level to reduce the adverse impact of air and noise pollution in disproportionately impacted and vulnerable communities from aviation. The resolution included specific recommendations for areas to study.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “aviation” AND “air pollution”, “aviation” AND “noise pollution,” and “aviation” AND “health equity.” Additional articles and relevant reports were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the Federal Aviation Administration (FAA) and United States (U.S.) Environmental Protection Agency (EPA), and websites for airport administration authorities were also reviewed for relevant information, particularly regarding current mitigation strategies utilized to reduce the adverse impacts of air and noise pollution form aviation.

DISCUSSION. Communities near airports and aviation corridors often face higher pollution exposure, compounded risks, and fewer resources for mitigation and therefore, aviation-related air and noise pollution contributes disproportionately to poor health outcomes in these communities. Evidence shows that aviation emissions contribute to adverse health outcomes, including respiratory and cardiovascular diseases, cognitive impairment, and cancer, while associated noise pollution increases risks for sleep disruption, mental health issues, and cardiovascular conditions. Despite technological advances and existing mitigation strategies, disparities in exposure persist, especially among low-income and minority neighborhoods near airports.

Both the EPA and the FAA play important roles in setting and enforcing standards around air and noise pollution from aircraft. The International Civil Aviation Organization, a United Nations agency serves as the global forum on issues related to international civil aviation. Aside from baseline federal standards, noise and air pollution management in the U.S. is largely dependent on the policies and regulations of local airports and municipalities. For example, airports develop their own noise compatibility programs to meet FAA requirements, which include land use strategies, operational procedures, and sometimes flight curfews. In general, as air pollution standards are set at the federal level, local airport policies and regulations focus more on noise pollution than air pollution, though some noise pollution reduction policies may also help reduce air pollution as well.

CONCLUSION. The expansion of commercial aviation continues to raise important concerns about air and noise pollution, particularly for communities near airports and other vulnerable groups. Ongoing policy, research, and legislative efforts are needed to address health and environmental concerns and to ensure strong protections are adopted for both affected communities and airport workers exposed to elevated levels of aviation pollution.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-A-26

Subject: Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 421-A-25 was referred by the American Medical Association (AMA) House of Delegates (HOD) and asked the following:

> That our AMA seek a study and report back providing recommendations at the federal level to reduce the adverse impact of air and noise pollution in disproportionately impacted and vulnerable communities from aviation, including the following areas:
> 1. Promotion of Sustainable Aviation Fuels: Advocate for the adoption of sustainable alternative jet fuels, which have been shown to decrease premature death rates in communities near airports and downwind.
> 2. Implementation of Noise Abatement Procedures: Encourage the use of flight paths and operational procedures that minimize noise impact on residential areas, particularly those inhabited by minority populations disproportionately impacted communities.
> 3. Investment in Noise Mitigation Infrastructure: Support the installation of soundproofing materials in homes, schools, and healthcare facilities located in high-noise areas to reduce the adverse health effects of noise pollution as well as non-combustion engines (i.e. solar or electric).
> 4. Community Engagement and Education: Foster partnerships with affected communities to raise awareness about the health impacts of air and noise pollution and involve them in decision-making processes regarding aviation operations.
> 5. Research and Monitoring: Advocate for ongoing research to monitor air and noise pollution levels in minority populations disproportionately impacted communities and study the effectiveness of implemented interventions.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “aviation” AND “air pollution”, “aviation” AND “noise pollution,” and “aviation” AND “health equity.” Additional articles and relevant reports were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the Federal Aviation Administration (FAA) and United States (U.S.) Environmental Protection Agency (EPA), and websites for airport administration authorities were also reviewed for relevant information, particularly in regard to current mitigation strategies utilized to reduce the adverse impacts of air and noise pollution form aviation.

BACKGROUND

Over the last fifty years, commercial air travel in the U.S. has seen substantial growth in both the number of flights and the expansion of airport facilities. The number of flights performed by U.S.

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carriers has grown from roughly five million annual departures in the mid-1970s to well over nine million by 2025.[1,2] From a global perspective, airplane traffic has grown at an annual average rate of roughly five percent over the last 30 years.[3] Private jet travel has also increased, with 2025 seeing a record-setting number of private jet flights globally at nearly four million.[4] The Federal Aviation Administration (FAA) is the primary federal agency responsible for regulating airport and airplane activities in the U.S.

While the increase in commercial aviation has made it much easier and cheaper for individuals to travel both domestically and internationally, there are concerns from communities who live around airports or along major flight paths about both air and noise pollution. Aside from baseline federal standards, noise pollution management is largely dependent on local airport policies and regulations. This report primarily focuses on public health concerns regarding air and noise pollution from commercial aviation, as opposed to military aviation. There are important differences in terms of the type of jet fuel used for commercial and military aircraft and noise levels are highly dependent on the size and type of aircraft, with military aircraft (e.g., fighter jets) having significantly different noise profiles and fuel needs compared to commercial airplanes.

DISCUSSION

Air Pollution

As compared to the gasoline used in everyday vehicles, airplanes use different formulations of fossil fuels, enabling airplanes to travel at high speeds, for great distances, and at high elevations without freezing the fuel. There are two main categories of commercial aviation fuels: jet fuel and aviation gasoline (AVGAS).[5] Jet fuel is a kerosine-based fuel aviation fuel that tends to be heavier with a higher flash point and freezing point than standard kerosene and is used for most commercial aviation. AVGAS, as the name suggests, is a gasoline-based aviation fuel that is typically used on smaller aircraft.[5] Unlike gasoline used in motor vehicles which has been unleaded for many decades, AVGAS still contains some amount of lead as it is helpful to meet high octane performance requirements in jet engines.[6]

The combustion of fuel in airplanes releases particulate matter, nitrogen oxides, sulfur oxides, volatile organic compounds, and other air toxics.[7,8] Ultrafine particulate matter (UFP), a term to describe particles smaller than 100 nanometers, is particularly concerning as airplane engines release large amounts of UFP and particulates of this size are able to penetrate deep into lung tissue.[9] A 2021 systematic review on the impacts of commercial airplane activity on air quality near airports found consistent evidence that UFP matter is elevated in and around airports while other studies found elevated levels of black carbon (otherwise known as soot), polycyclic aromatic hydrocarbons, and other criteria pollutants regulated by the EPA (e.g., sulfur dioxide, lead, and nitrogen dioxide).[8,9] As a result of growing private jet travel, private jet flights are also a growing source of air pollution, particularly in the U.S., which is where an overwhelming majority of private flights occur.[10] There are numerous factors that impact actual exposure to aviation air pollution, including the size of the airport and volume of air traffic, distance from the source, the prevailing meteorological conditions - which include wind speed and direction, humidity, and temperature – as well as the type, age and size of operational aircraft.[9] However, it has been demonstrated that the highest concentrations of UFP are generally measured downwind of the aircraft, but more research is needed to understand dispersion processes and other environmental factors that affect emissions and exposure levels.[9]

Differentiating air pollution from aviation versus other mobile pollution sources can be challenging. The EPA uses tools such as the Air Toxics Screening Assessment, which provides a

snapshot of outdoor air quality and estimates air pollutant concentrations, to measure health risks at the census tract level, estimating both cancer and non-cancer hazards from aviation and other mobile sources.[11] Aviation-related air pollution has been demonstrated to be associated with significant adverse health impacts, particularly in nearby communities. Air pollutants from aviation elevate risks for respiratory diseases (e.g., asthma and chronic obstructive pulmonary disorder), cardiovascular disease, cancer, cognitive impairment, and premature mortality.[9,12,13] Another study found exposure to UFP from aircraft emissions *in Utero* was positively associated with preterm birth among pregnant mothers.[14] A 2015 study assessing the global health impacts of civil aviation emissions attributed about 16,000 premature deaths per year globally to aviation emissions.[15]

Noise pollution

Noise pollution from aviation operations is another public health concern, which was raised as early as the late 1960s and early 1970s.[16] The EPA defines noise pollution as unwanted or disturbing sounds that interfere with normal activities, such as conversation or sleep, and/or diminish one's quality of life.[17] Normal decibel (dBA) levels generally range between about 35 to 70, with 60 dBA benchmarked as the noise level of a typical conversation. Prolonged exposure to noises at 85 dBA or over can lead to potential hearing loss.[18] The noise of a jet engine taking off is somewhere in the range of 120 to 130 dBA (depending on your proximity to the sound) and is considered unsafe.[18] The European Environment Agency classifies environmental noise—including aircraft noise—as the third most significant environmental cause of ill health in Europe after air pollution and temperature-related factors, emphasizing the scale and seriousness of the issue for policy makers and public health authorities.[19]

Noise created from aviation operations is different and unique in a few ways from noise created by everyday transportation and traffic patterns. First, the frequency of aircraft noise is different from traffic noise as it is dominated by low-frequency engine hums, high-frequency jet whine, and the sound of propellers moving depending on the speed of the aircraft. Second, the temporal pattern of aircraft noise – isolated with quick onset and decay (i.e., a plane flying over) – is distinct from traffic noise which tends to create a continuous, persistent background noise.[20] There are several tools airports can use to understand aviation noise. Many airports monitor noise levels through the placement of monitors at strategic places across the airports.[20] Additionally, sound level contour maps use a combination of sound measurements and sound mapping software to better predict where the highest levels of sound will occur, which can help with mitigation planning.[20]

A 2022 Australian report based on survey data of nearly 2000 residents found that airplane noise was associated with negative impacts to sleep, mental distress, and that aircraft noise interfered with daily activities in their homes.[21] A consensus paper on the health impacts from aviation noise pollution reported similar detrimental effects, including mental health impacts, sleep disruption, adverse effects on academic performance of children, and increases the risk for cardiovascular disease of people living in the vicinity of airports.[20] Increased rates of anxiety, depression, and general feelings of annoyance have been reported in communities exposed to persistent aircraft noise.[22] Aircraft noise is a major cause of sleep disruption, leading to fatigue, cognitive impairment, reduced productivity, and long-term mental health effects.[23] Studies highlight impaired learning, memory, and reading comprehension among children attending schools located near airports with high noise exposure.[24–26] Lastly, chronic exposure to aviation noise has been found to increase the risk for hypertension, heart attacks, and stroke.[27–29] In their most recent report, published in 2025, the European Environment Agency estimated that chronic exposure to transport-related noise (of which aviation is included) in Europe contributes to 66,000 premature deaths annually in Europe, around 50,000 new cardiovascular disease cases, and over half a million children experience reading difficulties and about 63,000 experience behavioral issues.[19]

Equity considerations

Communities near airports and aviation corridors, which tend to be lower-income, minority communities, often face higher pollution exposure, compounded risks, and fewer resources for mitigation and therefore aviation-related air and noise pollution contributes disproportionately to poor health outcomes in these communities.[30] For example, communities living near airports may have less access to mitigation resources (e.g., air purifiers or home soundproofing) and live close to other emission sources such as major roads and highways.[31] With the U.S., research has highlighted that integrating socioeconomic factors with pollution data is critical for identifying and addressing disparities with air pollution exposure.[32–35]

The FAA had previously created guidance for environmental justice analyses that required consideration disproportion and adverse effects on low-income or minority populations for any airport development action or any airport action subject to FAA approval.[36] However, due to executive order and identified priorities under the current administration, environmental justice and climate impacts are no longer required as part of FAA environmental analyses.[37] The FAA must still comply with the National Environmental Policy Act, which requires appropriate environmental impact assessments for relevant actions directly undertaken by the FAA.[37]

Airport workers, in particular those working on the ground in the airport tarmac (i.e., where airplanes approach and leave the airport terminal), represent another vulnerable population as they are exposed to significantly higher levels of aviation-related air and noise pollution for longer periods of time. Aviation workers are often exposed to noise levels that exceed safe noise thresholds and chronic exposure to high noise levels can cause permanent hearing loss, sleep disturbances, and heightened stress, potentially leading to cardiovascular problems.[38–40] The Occupational Safety and Health Administration (OSHA) sets protection standards for airport workers and requires hearing protection, such as ear plugs, muffs, or both, when noise exposure exceeds the action levels, which is 85 decibels, and mandates proper ventilation and personal protective equipment to mitigate air quality hazards.[41] OSHA also requires employers to provide hearing conservation programs and training, medical surveillance, and access to resources to reduce exposure levels and safeguard worker health. However, airport workers are a largely understudied population and more research is needed.[42]

Strategies to mitigate air and noise pollution

Both the EPA and the FAA play important roles in setting and enforcing standards around air and noise pollution from aircraft. Under the Clean Air Act, the EPA sets national standards limiting emissions of pollutants such as hydrocarbons, carbon monoxide, nitrogen oxides, particulate matter, and lead which apply to aircraft engines used in commercial aviation.[7] While the EPA sets air pollution standards, the FAA administers compliance and certification requirements. States and local authorities cannot set independent aircraft emissions standards. For noise pollution regulation, originally the EPA was responsible for aviation noise standards under the Noise Control Act of 1972, which also established the EPA's Office of Noise Abatement and Control, but since the early 1980s, direct regulatory authority for aircraft noise standards has been under the FAA.[17,43] However, the EPA still provides technical input and coordinates with federal partners and the public on relevant studies and recommended practices.[17] As part of their responsibilities, the FAA regulates the maximum noise level that an aircraft can emit through requiring aircraft to meet noise certification standards.

The International Civil Aviation Organization (ICAO), a United Nations agency that serves as the global forum on issues related to international civil aviation, has studied various noise abatement

strategies and developed a 'balanced approach' system that identifies 18 policy measures aimed at reducing noise, which are categorized into four pillars: (1) reduction of noise a the source (i.e., aircraft design and technical requirements), (2) land-use planning and management (e.g., reduce noise-sensitive land use around airports, such as residential areas), (2) operational procedures that focus on noise abatement (e.g., preferential runways and flight paths away from residential areas), and (4) aircraft operating restrictions (e.g., airport curfews).[16,44] The most common policy measures implemented were noise abatement procedures, engine run-up restrictions, preferential runways, and airport curfews.[16] Fifty percent of airports in North America use one to four of these policy measures, and nearly forty percent use five to nine of these policy measures.[16]

Modern aircraft technology has achieved significant improvements in noise levels through technological advances and lighter materials, with current jet aircraft being much quieter than first models released in the 1960s and 1970s.[45,46] ICAO's Chapter 14 standard, introduced in 2013 and effective in 2024, requires new aircraft models to be at least seven decibels quieter than previous standards.[47,48] Additionally, the aviation industry has set ambitious targets, including the Advisory Council for Aviation Research and Innovation in Europe's FlightPath 2050 vision of a 65 percent reduction in noise emissions by 2050 compared to 2000 levels.[49]

Aside from baseline federal standards, in the U.S. noise and air pollution management is largely dependent on the policies and regulations of local airports and municipalities. For example, airports develop their own noise compatibility programs to meet FAA requirements, which include land use strategies, operational procedures, and sometimes flight curfews. In general, as air pollution standards are set at the federal level, local airport policies and regulations focus more on noise pollution than air pollution, though some noise pollution reduction policies may also help reduce air pollution as well. A table is provided in the Appendix outlining the policies and programs of several major U.S. airports. It is also worth noting that many of these airports, in addition to the programs and specifics listed in the chart, implement some form of voluntary curfew where planes are not allowed to enter or leave between late hours of the night and early hours of the morning.

The regulatory approach for airport noise mitigation in the U.S. is noticeably different from the European Union (EU), which is more centralized and requires uniform reporting and standardized mitigation efforts across EU member countries. The European Noise Directive, the primary regulatory framework for airport noise management, requires major airports (over 50,000 movements per year) to regularly assess and report noise levels.[50] These assessments are used to create noise maps and action plans for mitigation involving stakeholders that include airports, airlines, local authorities, and communities. Additionally, EU noise exposure thresholds are generally 55 dBA during the day and 50 dBA during the night, while the FAA applies a Day-Night Average Sound Level threshold of 65 dBA.[19,43] In summary, Europe has a centralized regulatory structure with lower noise threshold limits and more proactive land-use planning as part of their noise mitigation efforts. On the other hand, the U.S. has a more decentralized approach, higher federal noise thresholds, and mitigation measures that often depend on local airport initiatives that focus on operational procedures and operating restrictions.

From an air pollution perspective, one promising solution is the integration of and eventual transition to sustainable aviation fuel. Sustainable Aviation Fuel (SAF) refers to a class of liquid fuels produced from renewable or waste-derived sources—such as used cooking oil, non-food crops, agricultural residues, municipal solid waste, and even CO_2 direct air capture.[51] Studies show that SAF produces less PM, sulfur oxides, and aromatics compared to conventional jet fuel, especially during the landing and take-off cycle at airports.[52,53] Thus, shifting toward SAF could lower emissions of these pollutants and improve local air quality, particularly for airport-adjacent

communities and airport workers. While SAF generally produces fewer soot particles and less NOx, the specific reduction of different air pollutants will vary by fuel type and process pathway.

Lastly, another benefit of SAF is its lower greenhouse gas (GHG) emission profile. Currently, the EPA estimates that commercial airplanes and large business jets contribute 10 percent of U.S. transportation emissions, and account for three percent of the nation's total GHG emissions.[54] SAF has the potential to reduce lifecycle GHG emissions by up to 80 percent (and potentially more), but it depends on the feedstock and production process of the SAF.[55–57] The U.S., EU, and other regions have implemented policy supports like the SAF Grand Challenge and FEETS (Fuels Eligible for ETS Support) to close cost gaps and scale up SAF production, aiming for large-scale deployment by 2030 and 2050 for meaningful climate and health impact.[58] The European Union Aviation Safety Agency has a set a minimum supply mandate for sustainable aviation fuels in Europe, starting with two percent in 2025 and increasing to 70 percent by 2050.[55]

LEGISLATION

There were two proposed bills in the 2025-2026 Congressional legislative session that are relevant to mitigation of air and noise pollution from airplanes. The first, entitled the 'Aviation Noise and Emissions Mitigation Act' proposed to develop pilot grant programs through the EPA to research and collect data on aircraft, airport noise, and emissions in order to develop mitigation strategies.[59] The second, the 'Sound Insulation Treatment Repair and Replacement Program Act', which passed as part of the National Defense Authorization Act for Fiscal Year 2026 on December 18, 2025, established a pilot program at up to four large airports to fund projects to repair or replace failing sound insulation systems in nearby residential homes.[60,61]

CURRENT AMA POLICY

While AMA does not have specific policy on aviation related pollution, it has several existing policies, supporting federal regulation and action on air pollution, including policy H-135.998, "AMA Position on Air Pollution" and D-135.985, "Air Pollution and Public Health."[62,63] AMA also has policy, D-135.996, "Reducing Sources of Diesel Exhaust, " which has a similar threat profile to airplane jet fuel.[64] Additionally, AMA has policy recognizing noise pollution as a public health issue, supporting ongoing federal environmental justice initiative, and the importance of environmental determinants of disease.[65,66]

CONCLUSIONS

The expansion of commercial aviation continues to raise important concerns about air and noise pollution, particularly for communities near airports and other vulnerable groups. Evidence shows that aviation emissions contribute to adverse health outcomes, including respiratory and cardiovascular diseases, cognitive impairment, and cancer, while associated noise pollution increases risks for sleep disruption, mental health issues, and cardiovascular conditions. Despite technological advances and existing mitigation strategies, disparities in exposure persist, especially among low-income and minority neighborhoods near airports. Ongoing policy, research, and legislative efforts are needed to address health and environmental concerns and to ensure strong protections are adopted for both affected communities and airport workers exposed to elevated levels of aviation pollution.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 421-A-25, and the remainder of the report be filed.

Our American Medical Association:

1. Supports increased surveillance, monitoring and research of air and noise pollution exposure from aviation, specifically for vulnerable populations, airport workers and nearby communities.
2. Encourages studies on the effectiveness of different interventions to mitigate air and noise pollution exposure from aviation.
3. Encourages airports to implement policy measures identified under the 'balanced approach' system to minimize noise exposure in surrounding communities, which could include changes to common flight paths, flight curfews, land use planning and community engagement, sound-proof insulation projects in nearby communities, and further technological advances to reduce jet engine noise.
4. Supports the phase-in of sustainable aviation fuels to reduce air pollution and climate impacts associated with aviation. (New HOD Policy)

Fiscal note: Minimal

APPENDIX

San Francisco International Airport (SFO)	SFO was the first airport in the US to implement an extensive noise insulation program. They provide acoustic improvements to single family residential properties, at no cost to the homeowner, that are inside a specific noise contour based on noise mapping. Additionally, in 2020, the SFO Noise Office launched its Noise Action Plan that have five objectives: promote quieter planes, introduce and prioritize quieter procedures, maintain and encourage active community engagement, expand and improve our noise monitoring program, and active land-use planning and mitigation.[67,68]
Los Angeles International Airport (LAX)	LAX has in place a Preferential Runway Use Policy that, when applicable and safe, has planes depart and land on the ocean side (west) instead of over neighborhoods (east side). It also has a LAX Residential Sound Insulation Program to treat homes, free of cost to the homeowner, close to LAX and reduce the noise level by at least 5 decibels.[69,70]
Westchester County Airport (HPN)	HPN has a noise abatement program, with several sub-programs that are each designed to reduce the noise levels created by aircraft operations. As part of these efforts, they have noise monitoring systems and adopted special programs for helicopters and large aircrafts.[71]
Long Beach Airport (LGB)	In collaboration with city efforts, Long Beach has one of the strictest noise-controlled airports in the US. With its Noise Ordinance, it lays out maximum single event and cumulative noise exposure limits and the ability to fine aircrafts owners/operators for multiple violations of their noise ordinance.[72]
Santa Monica Airport (SMO)	The airport's Fly Neighborly Program has several features that help reduce noise pollution. Such features include departure paths to be over the Penmar Golf Course instead of neighborhoods and special procedures for helicopters. There is also an imposed maximum noise exposure limit of 95 decibels for any single noise event.[73]
Tweed New Haven Airport (HVN)	HVN has distributed nearly $12 million dollars in federal funding to soundproof nearby homes, with the most recent phase being completed in 2023. They also have an online platform that the community can access to see aircraft activity and noise levels.[74]
Seattle-Tacoma (SEA-TAC) International Airport	SEA-TAC International Airport operates one of the most comprehensive aircraft noise reduction programs, including a sound insulation program dating back to 1985 that has insulated over 9,400 single-family homes. Their SEA Stakeholder Advisory Round Table serves as a forum for discussion and practical aircraft noise reduction initiatives.[75]
Chicago O'Hare International Airport	Chicago O'Hare International Airport operates the Airport Noise Management System, a comprehensive system providing actual measurement of aircraft noise levels in neighborhoods and suburban communities around O'Hare and Midway airports. The system includes permanent noise monitors and connects directly to FAA air traffic control radar to collect aircraft flight tracks, recording more than 5 million data points daily.[76]

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REPORT 10 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 508-A-25, referred by the House of Delegates (HOD), asked that our American Medical Association (AMA) study and report back with recommendations on appropriate minimum safety requirements/certifications (i.e., vehicle, Basic Life Support, Health Insurance Portability and Accountability Act) for non-emergency medical transportation (NEMT) and rideshare-based non-emergency medical transportation (RB-NEMT).

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “non-emergency medical transport”, “rideshare-based non-emergency medical transport”, “Uber Health”, “Lyft Healthcare”, and “rideshare-based medical transportation AND HIPAA”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. NEMT enables millions of patients, especially Medicaid beneficiaries, older adults, people with disabilities, and rural residents—to reach medical care when no other options exist. As a mandatory Medicaid benefit, it supports preventive services, chronic disease management, and continuity of care, but long-standing challenges such as missed pickups, variable service quality, uneven safety practices across states, and persistent program-integrity issues continue to affect reliability and outcomes. RB-NEMT has emerged as a flexible, on-demand supplement that can improve responsiveness and reduce delays for ambulatory riders, particularly for discharges and last-minute or recovery rides. However, RB-NEMT operates under a very different regulatory structure: drivers are independent contractors without medical or mobility-assistance training, and vehicles lack the accessibility features needed for higher-acuity riders. As a result, RB-NEMT is appropriate only for riders requiring minimal assistance and for select trip types. Traditional NEMT is guided by federal and state safety expectations—Medicaid rules, ADA accessibility standards, HIPAA privacy requirements, and state-level driver, vehicle, and insurance regulations—but these are applied inconsistently nationwide. In contrast, RB-NEMT currently has no evidence-based minimum safety standards, highlighting an important gap in oversight and the need for further research.

CONCLUSION. This report discusses traditional NEMT and emerging rideshare-based NEMT (RB-NEMT) and the distinctive roles they play within the health care transportation system. The report also outlines how traditional NEMT is governed by longstanding federal and state safety expectations but continues to experience variability in implementation and operational challenges that affect reliability and quality. Although, RB-NEMT offers flexibility and responsiveness for certain riders and trip types, it operates within a different regulatory framework and lacks evidence-based minimum safety standards, with existing studies providing only limited guidance—primarily related to appropriate rider matching. Because of these differences and the gaps identified, the recommendations focus on three overarching needs: recognizing transportation as essential to equitable access to care; promoting greater consistency in the application of existing NEMT safety standards across states; and supporting further research to evaluate RB-NEMT safety risks and develop evidence-based minimum safety requirements before prescriptive operational standards can be responsibly established.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 10-A-26

Subject: Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 508-A-25, "Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation," was introduced by the Medical Student Section and was referred. It asked the following:

> That our American Medical Association (AMA) study and report back with recommendations on appropriate minimum safety requirements/certifications (i.e., vehicle, Basic Life Support, Health Insurance Portability and Accountability Act) for non-emergency medical transportation (NEMT) and rideshare-based non-emergency medical transportation (RB-NEMT).

This report provides a review of the topic and makes policy recommendations.

BACKGROUND

Transportation is critical for access to medical care, with nearly six million Americans annually having transportation barriers impacting timely access to care including missed appointments.[1] Traditional non-emergency medical transport (NEMT) programs, typically funded through Medicare or Medicaid, provide essential transportation for vulnerable populations, including the elderly, disabled, and rural residents, via taxis, vans, or buses.[2] However, these services often suffer from reliability issues such as late arrivals and no-shows, which can disrupt continuity of care and increase health care costs.[3] In response to these limitations, rideshare-based NEMT (RB-NEMT) programs have emerged, leveraging platforms like Uber and Lyft to expand access.[4] These services have demonstrated improvements in appointment attendance, reduced wait times, and lower costs, while also enhancing patient satisfaction.[4] Despite these benefits, RB-NEMT drivers are typically independent contractors with minimal training in patient confidentiality, basic life support (BLS), or medical liability protocols.[4,5] This lack of standardized training and credentialing raises concerns about patient safety and quality of care.[4,5]

RB-NEMT proponents note that it is appealing because it may provide more flexibility for passengers; it is well suited for last-minute rides, like hospital discharges; and may reduce waiting times and cost.[6] Additionally, RB-EMT can better track rides and collect data, potentially addressing quality, fraud, waste, and abuse.[7] Conversely, critics of RB-NEMT note that issues include lower pay for drivers, lack of access in rural areas, inadequate driver screening, and safety issues for drivers and riders.[8] Because the NEMT population is more likely to be low-income, older adults, and individuals with disabilities, additional specialized training for drivers is needed.[9]

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METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “non-emergency medical transport”, “rideshare-based non-emergency medical transport”, “Uber Health”, “Lyft Healthcare”, and “rideshare-based medical transportation AND HIPAA”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

Transportation is a fundamental component of accessing routine, nonemergency medical care.[10] Transportation challenges to health care are disproportionately experienced by individuals who are low-income, older adults, non-White, women, and less educated, many of whom are Medicaid enrollees.[11] An estimated 25 percent to 55 percent of Medicaid enrollees missed, arrived late to, or did not try to go to a health care appointment because of transportation issues.[10] Adults and children who missed medical appointments due to transportation issues had extensive comorbidities and a significantly higher prevalence of health conditions compared with those who missed care for other reasons.[12] Inconsistent care due to transportation challenges can negatively affect health and increase preventable emergency department visits, particularly for individuals with chronic conditions.[10] Missed appointments do not just cause delays in medical care. They also cost the U.S. health care system $150 billion annually.[13]

BACKGROUND ON NONEMERGENCY MEDICAL TRANSPORATION (NEMT)

What is NEMT?

NEMT is a system that provides individuals with transportation to medical and health-care services when they lack other means of transport.[14] As a mandatory Medicaid benefit, NEMT plays a central role in reducing transportation-related barriers and ensuring that beneficiaries, particularly those who are older, disabled, or managing chronic conditions, can reliably access needed care.[15,16] Although all states must offer NEMT, the scope of what is covered, how services are delivered, and the overall quality of transportation vary considerably across state programs.[4] States may differ in the number of trips they authorize, whether prior approval is required, and whether small copayments are allowed, reflecting differences in beneficiary needs, delivery systems, and geographic context.[17]

Medicaid has covered NEMT since the program’s creation in 1966, with federal authority grounded in 42 CFR § 440.170.[18,19] Congress later reinforced this requirement in the Consolidated Appropriations Act of 2021, explicitly recognizing transportation network companies (TNCs) as allowable NEMT providers.[20,21] Over time, states have adopted three primary approaches to administering NEMT: state-run fee-for-service systems, managed care arrangements in which health plans coordinate transportation directly or through subcontractors, and broker-based models where states contract with a dedicated transportation broker to manage the benefit.[4,19] States most commonly rely on the brokerage model, which research suggests may improve oversight, reduce fraud and abuse, and help contain costs, particularly in capitated arrangements where brokers have fewer incentives to oversupply trips.[22]

Because states retain significant flexibility in implementing NEMT, program structure and operational practices vary widely.[4,6,19] Some states impose extensive credentialing, documentation, or quality-assurance requirements, while others take a lighter regulatory approach. These

differences shape the beneficiary experience and influence program integrity, cost management, and access to care.[4,19,22] The federal requirement to provide transportation remains consistent across the country, but how NEMT is delivered, and how effectively it meets patients' needs, ultimately depends on state choices regarding administration, contracting, and service design.[4,21]

Types of NEMT services

People who rely on NEMT have a wide range of physical, cognitive, and functional abilities. To ensure that each individual receives transportation that matches their needs, NEMT services are commonly organized into four broadly recognized levels of assistance.[4] These levels reflect how much support a rider requires before, during, and after the trip.[4]

Hand-to-Hand (H2H). H2H service is intended for individuals who require continuous assistance throughout the transportation process or who must maintain a formal chain of custody.[4,23] This includes riders unable to travel independently whether due to cognitive, sensory, or significant physical impairments, and individuals who must be transferred directly between responsible adults.[4,23] Children, for example, typically fall under H2H because they require a parent, guardian, or caregiver to accompany them for the full duration of the trip.[4,23] The driver or attendant plays an active support role, ensuring the rider is safely handed off at both pickup and drop-off locations.[4,23]

Door-to-Door (D2D). D2D service is appropriate for individuals who can ambulate with some independence but still require light physical assistance from the driver.[4,23] This support may include walking with the rider from their front door to the vehicle, assisting with entering and exiting the vehicle, opening doors, fastening seatbelts, or helping stow mobility devices and belongings.[4,23] Assistance in this category does not involve lifting, securement, or continuous monitoring but instead provides the modest, task-specific help some riders need to safely complete the trip.[4,23]

Curb-to-Curb (C2C). C2C is suitable for riders who can reach the curb independently and enter the vehicle with little or no driver assistance.[4,23] The driver remains responsible for operating the vehicle safely and verifying the passenger's identity but does not accompany the rider to or from their residence or destination doors.[4,23] This service level is widely used for riders who remain ambulatory and do not require support beyond the immediate boarding process.[4,23]

Area-to-Area (A2A). A2A serves individuals who are fully ambulatory and can walk longer distances—for example, from their residence to a designated pickup point, such as a bus stop or centralized meeting area.[4,23] Unlike C2C riders, who may only be comfortable walking a short distance to the curb, A2A riders can travel farther and access transportation from non-residential pickup sites.[4,23] This service is frequently used in transit-rich or campus-style settings where stops are located away from individual homes.[4,23]

Assigning a rider to the correct service level requires considering functional ability, cognitive status, environmental factors, and safety needs.[4,23] These categories help transportation providers, care coordinators, and health plans determine the most appropriate and safe mode of travel.[4,23] However, no national dataset currently captures the number of individuals who fall into each service level, and the true distribution likely varies by state, geography, and beneficiary population.[4]

How are NEMT rides scheduled?

NEMT rides may be scheduled either by the individual or by a care provider, depending on the state, the beneficiary's insurance program, and the administrative model used for NEMT.[4,6] In most states, scheduling occurs through a broker or managed care organization that operates a call center

or dispatch system.[4,6] When a request is made, the broker first verifies the individual's eligibility for NEMT and determines whether the ride meets coverage criteria.[4,24] If approved, the broker then assigns the trip to an appropriate transportation provider within its network. The selection of a transportation mode is guided by several factors, including the rider's functional needs, the availability of transportation options (such as proximity to a bus stop), and environmental conditions like extreme heat or cold, which may influence safety or accessibility.[4,24] Scheduling decisions also consider whether the ride is planned in advance or a last-minute request, as well as system-level constraints such as cost or vehicle availability.[4,24] Once assigned, a trip may be direct, transporting a single passenger from pickup to drop-off, similar to rideshare or taxi service, or shared, with multiple passengers boarding and disembarking along the route, similar to paratransit operations.[4,15,24]

Benefits of NEMT

Access to NEMT plays a critical role in reducing barriers to care for Medicaid beneficiaries and other transportation-vulnerable populations.[25] Studies consistently demonstrate that providing reliable transportation is associated with increased use of preventive and primary care, reduced reliance on emergency departments and inpatient services, and more timely access to treatment for individuals with chronic health conditions.[1,26,27] Evidence also indicates that NEMT can generate meaningful cost savings for the health system.[4,8,28] Even when accounting for transportation costs, NEMT has been linked to reductions in avoidable hospitalizations and improved management of chronic diseases.[4,8,28] National estimates suggest that Medicaid finances approximately 103 million NEMT trips annually, at an average cost of $26–$29 per trip, underscoring the scale and relatively low per-ride expense of the benefit.[4,29]

Common issues with NEMT

NEMT has long faced operational and oversight challenges that affect both the reliability and integrity of the benefit. A 2016 Government Accountability Office (GAO) review identified persistent concerns about late or missed pickups, and such delays often resulted from complex routing patterns. For example, traditional NEMT trips may involve multiple passengers and numerous stops which can significantly lengthen travel times and reduce patient satisfaction.[30] The report also highlighted broader program-integrity vulnerabilities, including fraud, waste, inefficiencies, and insufficient oversight.[30] States reported difficulty verifying eligibility, confirming that the transportation mode matched patient needs, and ensuring that trip destinations were appropriate for covered services.[30] Investigations by the HHS Office of Inspector General (OIG) further revealed substantial improper payments: between 2005 and 2011, five states collectively paid an estimated $63 million for rides that did not meet NEMT requirements.[31] Additional issues included billing for multiple trips when only one was needed, billing for deceased beneficiaries, and inappropriate up-charging—for example, assigning a costly ambulance trip for routine dialysis transport when a lower-acuity mode would have sufficed.[30,31]

Together, these findings underscore the complexity of administering NEMT across multiple delivery models, each with different data systems, credentialing requirements, and oversight capabilities.[28,30,31] Variability across states and contractors can make it difficult to consistently ensure that drivers, vehicles, and trips meet program standards.[4,28,30,31] These well-documented challenges continue to shape federal and state efforts to strengthen screening, monitoring, and trip-validation processes across both traditional and emerging NEMT modalities.[28,30,31]

What safety standards exist for NEMT?

Current minimum safety standards for NEMT are shaped primarily by federal Medicaid requirements, the American Disabilities Act (ADA) accessibility regulations, and Health Insurance Portability and Accountability Act (HIPAA) privacy rules.[18,32–35] At the federal level, Medicaid's "transportation assurance" obligates states to ensure necessary transportation and describe how they will provide it, which forms the structural foundation for safety oversight in all NEMT programs.[36] Federal rules for managed care and Prepaid Ambulatory Health Plans (PAHPs) require states and contracted NEMT entities to meet selected standards related to enrollee rights, information disclosure, and operational capacity.[37–40] The ADA further establishes technical minimums for accessible transportation, such as lift specifications, securement systems, and equipment maintenance, which apply whenever NEMT providers transport riders with mobility disabilities.[33] HIPAA compliance is required when protected health information is transmitted for scheduling or coordinating NEMT, which increasingly affects rideshare-integrated NEMT programs.[32]

At the state level, minimum safety standards become more detailed and prescriptive, especially regarding driver qualifications, vehicle conditions, and insurance requirements.[41,42] Most states require criminal background checks, motor-vehicle-record screenings, exclusion (LEIE) checks, drug testing, and periodic re-credentialing.[42–44] Vehicle standards commonly include documented safety inspections, compliance with state transportation codes, adherence to ADA equipment requirements (for accessible vehicles), and routine preventive maintenance.[33,36,43] Insurance requirements typically mandate commercial auto liability, general liability, and workers' compensation, with specific minimum coverage levels defined by state Medicaid contracts or broker agreements.[43,45] These standards serve as the baseline for ensuring safety and provider accountability in traditional NEMT settings.[18,32,33,36–40,43–45]

However, reports have identified recurring vulnerabilities, such as use of unqualified drivers, improperly documented trips, and unsafe or uninspected vehicles, prompting states and brokers to require pre-trip eligibility verification, real-time GPS validation, incident reporting, and strict record-keeping.[30,31] Voluntary accreditation bodies such as the Non-Emergency Medical Transportation Accreditation Commission (NEMTAC) have also emerged, offering consensus standards for driver training, securement practices, quality assurance, and organizational safety culture, which states, brokers, and plans increasingly treat as benchmarks for high-quality NEMT.[46] It should be noted that the 2002-2025 NEMTAC Provider Standard draft is currently open for public comment.[47] The NEMTAC Provider Standard is a comprehensive, American National Standards Institute aligned draft framework designed to establish national, consensus-based safety and operational expectations for NEMT providers.[47] It outlines structured requirements across organizational management, operations, staffing, and compliance, with the goal of elevating service quality, improving safety, and supporting uniformity across diverse state Medicaid environments.[47]

BACKGROUND ON RIDESHARE BASED NONEMERGENCY MEDICAL TRANSPORATION (RB-NEMT)

What is RB-NEMT?

Rideshare-based non-emergency medical transportation (RB-NEMT) refers to the use of transportation network companies (TNCs), such as Uber and Lyft, to provide medical transportation for riders.[4,48,49] Over the past decade, rideshare platforms have expanded rapidly nationwide, creating new opportunities to supplement traditional NEMT services.[50] Their entry into the NEMT market was driven by several converging trends: the growing availability of TNC

services, increases in the Medicaid and Medicare Advantage populations, rising demand for transportation among older adults, and capacity constraints within traditional NEMT provider networks.[51,52] Lyft first entered the NEMT space in 2016, followed by Uber in 2018, integrating their platforms with brokers and health plans to deliver curb-to-curb transportation for eligible beneficiaries.[51,52]

In an RB-NEMT model, brokers or health plans schedule rides through dedicated TNC health-care platforms rather than through the consumer-facing app.[4] Riders do not need a smartphone to participate, and TNC drivers generally do not know they are transporting a Medicaid or medically referred passenger, only that the ride was pre-arranged through a third party.[4,53] Early evaluations, including pilot programs and industry analyses, suggest that RB-NEMT may reduce missed pickups, improve punctuality, and lower transportation costs, particularly for ambulatory riders.[4,54,55] For example, one health system reported substantial reductions in rider complaints and no-show rates, along with notable cost savings when compared with taxi-voucher programs.[4,56] While these findings draw from industry-sponsored work and may not be generalizable, they highlight the potential operational advantages of rideshare integration.[4,56]

State and federal policy around RB-NEMT continues to evolve, and important gaps remain between NEMT regulatory expectations and what TNCs are structurally designed to provide. For example, state NEMT rules often require driver training in CPR or first aid, routine drug testing, specific insurance coverage, or specialized vehicle licensing, requirements that do not align with the independent-contractor model used by TNCs.[4,42] Vehicles used in RB-NEMT may also lack features required for certain NEMT trips, such as wheelchair securement systems or state-mandated license plates.[4,9]

What types of NEMT services and rider are best for RB-NEMT?

Studies have found that RB-NEMT is most appropriate for individuals who require minimal to no physical assistance and can safely use curb-to-curb (C2C) or area-to-area (A2A) services.[4,54,55,57] While RB-NEMT is primarily suited for riders needing low-assistance service, studies have noted that it can also be effective for specific trip types that benefit from flexibility and rapid deployment. RB-NEMT is a strong option for inpatient and outpatient discharges, where timing is unpredictable and traditional NEMT often requires advance scheduling.[4,54,55,57] It is also well suited for last-minute appointments, recovery rides following a missed pickup, and off-hour or high-volume periods, when traditional fleets may be limited.[4,57] In rural areas, where NEMT access is often sparse, RB-NEMT can expand transportation availability when rideshare networks operate locally.[58] By assigning ambulatory riders and flexible trip types to RB-NEMT, health plans and brokers can preserve traditional NEMT's specialized vehicles and trained personnel for riders who require D2D or H2H support.[4,59] This targeted assignment improves overall system efficiency, helps address capacity constraints, and ensures that higher-acuity riders retain access to appropriately equipped and staffed transportation.[4,59]

What safety standards exist for RB-NEMT?

Current minimum safety standards for RB-NEMT are far less formalized than those governing traditional NEMT, but several expectations have emerged through multiple studies.[4] At present, the only widely supported minimum standard is rider-service matching, meaning RB-NEMT should be used exclusively for low-assistance riders (i.e., those who can safely use C2C or A2A transportation) and do not require physical assistance, medical monitoring, or specialized mobility equipment.[4,54,59] Evidence consistently shows that rideshare vehicles cannot safely accommodate motorized wheelchairs, scooters, or securement-dependent devices, and drivers lack required

training in passenger assistance or medical support.[4,54,55,59] In addition, states and brokers implementing RB-NEMT generally rely on platform-level safety controls (i.e., identity verification, GPS tracking, and basic background checks already required of rideshare drivers) rather than NEMT-specific safety certifications.[4,60]

Beyond rider suitability, the most consistent minimum safety expectations relate to privacy and data handling, not clinical or operational safety. Because arranging RB-NEMT requires the transmission of pickup and destination details that may constitute protected health information (PHI), RB-NEMT platforms must operate through HIPAA-aligned scheduling dashboards, with Business Associate Agreements (BAAs) executed between the rideshare intermediary and the covered entity.[4,61–63] For example, Uber Health notes that platforms restrict driver-visible information to the "minimum necessary" (i.e., name and pickup point) and maintain encrypted PHI storage separate from consumer rideshare systems.[64] However, there are no federally defined driver-training requirements, no RB-NEMT-specific vehicle standards, and no validated safety benchmarks for transporting medically vulnerable individuals through TNCs.[4] As multiple studies have emphasized, RB-NEMT safety standards remain largely undeveloped, with the current minimums driven by platform safeguards, state-level rider selection criteria, and HIPAA compliance.[4,33,57]

EXISTING AMA POLICY

The AMA has limited policy on non-emergency medical transportation. AMA Policy H-130.954, "Non-Emergency Patient Transportation Systems," states our AMA supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems, and encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

CONCLUSION

NEMT plays a vital role in enabling timely access to health care, particularly for Medicaid beneficiaries, older adults, people with disabilities, and individuals living in rural or underserved communities.[1,12,28] For these populations, transportation is not simply a logistical need, but a foundational determinant of whether patients can obtain preventive services, maintain continuity of care, and effectively manage chronic conditions.[65] Traditional NEMT systems, delivered through state programs, brokers, and managed care plans, continue to serve riders who require specialized vehicles, trained personnel, or hands-on support.[4,19,22] However, despite their longstanding role in supporting access, these systems face persistent challenges in reliability, oversight, and operational consistency that can undermine their effectiveness.[30,31] In recent years, RB-NEMT has emerged as a flexible and on-demand complement to traditional models.[51,52] RB-NEMT may offer advantages such as rapid response times, broad geographic availability, and improved scheduling capacity for ambulatory riders and last-minute needs.[54,55] Yet this model operates within a fundamentally different regulatory structure. Rideshare vehicles are not equipped for mobility-device securement, and drivers, who function as independent contractors, are not trained to provide physical assistance or medical oversight.[4] As a result, RB-NEMT is appropriate only for certain riders and specific types of trips, and its safe integration requires careful matching of riders to service levels that align with vehicle capabilities and driver competencies.[4,54,55,59]

While traditional NEMT is guided by long-standing safety expectations grounded in federal Medicaid requirements, ADA accessibility standards, HIPAA privacy protections, and state-level driver, vehicle, and insurance regulations, these expectations are applied unevenly across states and

delivery models.[18,32,33,36–40,42,44,45,61–63] This variability underscores the need for greater consistency and coordination in how minimum safety standards are implemented for traditional NEMT. In contrast, RB-NEMT lacks comparable, evidence-based safety standards altogether. Existing studies provide clear guidance only on the importance of appropriate rider selection for RB-NEMT; beyond this, current research is insufficient to define validated safety requirements for driver training, vehicle specifications, or operational procedures.[4,60,64] Moreover, differences between state NEMT rules and TNC operating frameworks further complicate the development of uniform RB-NEMT safety expectations.[4,41,42]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 508-A-25 and the remainder of the report be filed.

1. Our AMA acknowledges that transportation is a foundational component of health care access and supports policies that ensure vulnerable populations can obtain necessary medical care.
2. Our AMA supports efforts to promote greater consistency and coordination in the minimum safety standards that guide traditional non-emergency medical transportation across states and delivery models and encourages ongoing evaluation of these standards as transportation systems and patient needs evolve.
3. Our AMA acknowledges that rideshare-based non-emergency medical transportation (RB-NEMT) is an expanding component of medical transportation and supports continued research to assess safety risks and establish evidence-based minimum safety requirements to help ensure RB-NEMT can be integrated safely and appropriately into patient care. (New HOD Policy)

Fiscal Note: Modest

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards

Referred to: Reference Committee D

Whereas, the American Medical Association recognizes that food safety and the reduction of harmful chemical additives in the food supply represents a critical public health priority affecting millions of Americans; and

Whereas, the European Union has implemented more stringent regulations regarding food additives, artificial colors, preservatives, and other chemical substances, resulting in significantly lower exposure rates to potentially harmful compounds compared to the United States; and

Whereas, numerous peer-reviewed studies have linked certain food additives commonly used in the United States—including artificial food dyes, certain preservatives, and flavor enhancers—to adverse health outcomes including hyperactivity in children, allergic reactions, and potential carcinogenic effects; and

Whereas, the current U.S. food regulatory framework allows the use of over 3,000 food additives, many of which are prohibited or restricted in European markets due to safety concerns; and

Whereas, American families deserve access to food products that meet the same safety standards enjoyed by consumers in Europe and other developed nations; and

Whereas, the Trump Administration has expressed commitment to improving American health outcomes and reducing regulatory barriers that may impede food safety improvements; and

Whereas, collaboration between medical professionals and government agencies is essential to develop evidence-based policies that protect public health while supporting American food producers and manufacturers; therefore be it

RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, and relevant administration appointees to:

1. Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in Europe
2. Evaluate the scientific evidence regarding health impacts of these substances
3. Develop a prioritized timeline for regulatory action on the most concerning additives
4. Create transition pathways for food manufacturers to adopt safer alternatives

(Directive to Take Action); and be it further

RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 3/25/26

RELEVANT AMA POLICY

Food Safety - Federal Inspection Programs H-150.967
Our American Medical Association encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety.
Citation: CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

FDA Drug Safety Policies D-100.978
Our American Medical Association will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients.
Citation: Sub. Res. 505, A-08; Reaffirmed: CSAPH Rep. 1, A-21

Addressing the Health Impacts of Ultraprocessed Foods H-150.914
1. Our AMA supports and promotes public awareness and education about the differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.
3. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.
4. Our AMA supports increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Citation: Res. 430, A-25

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Reform the US Farm Bill to Improve US Public Health and Food Sustainability: Our American Medical Association supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.
Citation: Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
1. Our American Medical Association acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging.
2. Our AMA encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting

options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system.

3. Our AMA encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price.
4. Our AMA encourages physicians to
    a. counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines.
    b. work with local school districts to promote healthy beverage and food choices for students.
5. Our AMA recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives.
6. Our AMA supports that any excise taxes are reinvested in community programs promoting health.
7. Our AMA will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.

Citation: CSAPH Rep. 03, A-17; Modified: Res. 429, A-22

Fast Food H-150.979
The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer low fat alternatives to highly saturated fat foods.
Citation: Sub. Res. 123, A-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948
Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.
Citation: Sub. Res. 411, A-04; Reaffirmed: A-07; Reaffirmed in lieu of Res. 413, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24

The Health Effects of High Fructose Syrup H-150.919

1. Our American Medical Association recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS.
2. Our AMA encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response.
3. Our AMA in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet.

Citation: CSAPH Rep. 8, A-23

Food Additives H-150.998
Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.
Citation: Sub. Res. 4, A-776; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10; Reaffirmed; BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-26)

Introduced by: Oklahoma, American Association of Public Health Physicians, Mississippi, Tennessee

Subject: Strengthening Public Health Protections Against Raw Milk–Associated Illness

Referred to: Reference Committee D

Whereas, raw unpasteurized milk poses significant risks of foodborne illness from pathogens such as Campylobacter, Shiga toxin-producing E. coli, Salmonella, Listeria, avian influenza, Brucella, Tuberculosis, and others, even from herds appearing healthy[1,5,6]; and

Whereas, from 1998-2018, raw milk caused at least 202 U.S. outbreaks resulting in 2,645 illnesses, 228 hospitalizations, and severe complications including hemolytic uremic syndrome, Guillain-Barré syndrome, sepsis, and death[1,5]; and

Whereas, children under 5 years are at highest risk for severe outcomes, including long-term kidney damage and neurological harm, yet cannot advocate for themselves against parental or caregiver choices exposing them to these preventable dangers[2,5]; and

Whereas, pregnant individuals consuming raw milk risk transmitting Listeria to fetuses, leading to miscarriage, stillbirth, preterm birth, or neonatal sepsis, disproportionately affecting the most vulnerable pediatric populations[1,2,5]; and

Whereas, the New Mexico Department of Health warned New Mexicans to avoid raw dairy products following the death of a newborn from Listeria infection in February of 2026 [9]; and

Whereas, claims of nutritional superiority or health benefits from raw milk lack high-quality evidence, while pasteurization eliminates pathogens without reducing essential nutrients[4,6,7,8]; and

Whereas, major public health authorities including the FDA, CDC, and AAP strongly advise against raw milk consumption, particularly for children, pregnant people, and immuno-compromised individuals[1,2,5]; and

Whereas, our AMA policy H-150.980, Milk and Human Health, reaffirms the policy that all milk sold for human consumption should be required to be pasteurized; therefore be it

RESOLVED, that our American Medical Association oppose the consumption and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications (New HOD Policy); and be it further

RESOLVED, that our AMA urge congress and state legislatures to prohibit interstate sale of raw unpasteurized milk, strengthening current FDA regulation (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with like-minded organizations, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw,

unpasteurized milk and dairy products for children, targeting parents, schools, and childcare providers (Directive to Take Action); and be it further

RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for general public and for members of vulnerable populations (Directive to Take Action); and be it further

RESOLVED, that our AMA support banning raw milk in settings accessible to children, such as schools and daycare facilities. (New HOD Policy)

Fiscal Note: Major – $69,695. Joint development and dissemination of education initiatives.

Received: 4/7/26

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RELEVANT AMA POLICY

Milk and Human Health H-150.980
The AMA reaffirms its policy that all milk sold for human consumption should be required to be pasteurized.

Food-Borne Illness H-440.904
Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to (1) educate physicians and the public on measures to prevent food-borne illness; and (2) ensure enforcement of existing regulations for the safe production, handling, and transportation of food items.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-26)

Introduced by: New Jersey

Subject: AMA's continued support for COVID-19 vaccination in pregnant individuals and children

Referred to: Reference Committee D

Whereas, on May 27, 2025, the CDC removed its recommendation for COVID-19 vaccination in healthy pregnant individuals and children aged 6 months–17 years (1); and

Whereas, pregnancy is a recognized high-risk condition for severe COVID-19 illness and infants born to unvaccinated mothers are more vulnerable in the first six months of life (2); and

Whereas, the AMA has previously demonstrated that the COVID-19 vaccination during pregnancy is safe for both mother and infant with no increase in miscarriage, preterm birth, or adverse fetal outcomes (3); and

Whereas, existing AMA policy D-440.921 ("An Urgent Initiative to Support COVID-19 Vaccination and Information Programs") emphasizes the necessity to promote the integrity of COVID-19 vaccine information; and

Whereas, the AMA does not have existing policy explicitly recommending ongoing Covid-19 vaccination for healthy pregnant individuals and children aged 6 months through 17 years old; therefore be it

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore explicit recommendations for COVID-19 vaccination of pregnant individuals and young children aged 6 months to 17 years. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/2026

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RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

[1]AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-26)

Introduced by: New Jersey

Subject: Develop Climate-Conscious Resources for Physicians

Referred to: Reference Committee D

Whereas, climate change poses a significant and immediate threat to public health, with impacts that include increased heat-related illnesses, respiratory conditions, vector-borne diseases, and disruptions to healthcare delivery; and

Whereas, the healthcare sector, including the U.S. healthcare system, is both affected by climate change and a significant contributor to greenhouse gas emissions; and

Whereas, physicians and other healthcare professionals play a vital role in advocating for environmentally sustainable practices within the healthcare system and in educating patients about the health impacts of climate change; and

Whereas, initiatives developed by a national foundation has been very successful at decreasing unnecessary tests, treatments, and procedures; and

Whereas, a national foundation has developed a comprehensive resource, broken down by specialty, focused on the intersection of climate change and healthcare, providing guidance, educational materials, and actionable recommendations to reduce the environmental impact of clinical practices; therefore be it

RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions (New HOD Policy); and be it further

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities (New HOD Policy); and be it further

RESOLVED, that our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-26)

Introduced by: New Jersey

Subject: Studying the Environmental Impact of Ambient Clinical Intelligence Use

Referred to: Reference Committee D

Whereas, ambient clinical intelligence is proving to be an important technology tool for strengthening the physician-patient relationship and reducing physician burnout; and

Whereas, the demand for ambient clinical intelligence tools is significantly increasing and has a projected growth of by 38.62% from 2025 to 2030; and

Whereas, the growth of data centers to support ambient clinical intelligence is also being built to accommodate demand and place a significant strain on the electrical grid with potential public health implications; and

Whereas, data centers, as part of their routine operation, account for 1% of global electricity usage and this percentage is predicted to grow to 21% by 2030; and

Whereas, training a single AI model can emit over 284,000 kg of carbon dioxide; and

Whereas, built data centers come with an additional environmental cost of soil damage in areas where mineral extraction is done, pollution from the manufacturing of data center components and electronic waste from retired hardware, which have grown to more than 50 pounds annually with only about 20% of it is recycled; and

Whereas the direct impact on public health and infrastructure caused by data centers have been quantified to be as high as $5.4 billion dollars in a 5-year period; therefore be it

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to voluntarily report emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RESOLVED, our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action); and be it further

RESOLVED, our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-26)

Introduced by: Medical Society of New Jersey

Subject: Reduce Environmental Impact of Medical Journals

Referred to: Reference Committee D

Whereas, the U.S. healthcare system generates a tremendous amount of waste, contributing 8.5% of greenhouse gas emissions and producing 4 billion pounds of waste annually; and

Whereas, there are over 1 million physicians in the United States, each of whom receives, on average, multiple medical journals monthly; and

Whereas, these journals are commonly wrapped in low-density polyethylene (LDPE), a material that, according to the Environmental Protection Agency (EPA), contributed 500,000 tons to U.S. landfills in 2015; and

Whereas, plastics, including LDPE, have been found in human blood, stool, and urine, and are known to cause cell death, allergic reactions, and inflammation; and

Whereas, a majority of physicians in a recent study expressed a preference for digital formats over print versions of medical journals; therefore be it

RESOLVED, that our American Medical Association's medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage specialty societies to require physicians to opt in to receive print versions of journals, with the default option being to receive electronic-only versions. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Colorectal Cancer in Alaskan Native Patients

Referred to: Reference Committee D

Whereas, colorectal cancer is on the rise among Americans younger than age 50[1]; and

Whereas, the United States (U.S.) Preventive Services Task Force (USPSTF) currently recommends that colorectal cancer screening begin at age 45 for average-risk adults[2]; and

Whereas, while incidence and mortality attributable to colorectal cancer has decreased among Americans, disparities have worsened among Alaskan Natives, with incidence exceeding 60 to 90 cases per 100,000 persons in this population–the highest worldwide[3,4]; and

Whereas, the age-adjusted incidence of colorectal cancer among Alaskan Natives exceeds that of the non-Hispanic white population across the entire adult lifecourse[5]; and

Whereas, from 2014–2018, the colorectal cancer incidence rate among the Alaska Native population (67.1/100,000) was over twice as high as the rate for the White population in Alaska (26.4/100,000), and over three times higher than the rate among Asian/Pacific Islander persons and Black persons in Alaska (20.3/100,000 and 17.1/100,000, respectively)[5]; and

Whereas, investigations of the troubling increase in colorectal cancer incidence and mortality among Alaskan Natives suggests contributions from genetic, environmental, social, and structural factors as key drivers of this disparity[5,6]; and

Whereas, in 2013, the Alaska Tribal Health System and Alaska Native Epidemiology Center (a federally-designated public health authority) recommended that persons with Alaska Native ancestry begin screening colonoscopies at age 40, which was driven by robust, powered epidemiological evidence in the Alaskan Native population[3,4,5-,8]; and

Whereas, uptake of this recommendation may be limited among physicians due to the USPSTF declining to implement a population-specific recommendation for this group due to low representation of Alaskan Natives in general population studies investigating colorectal cancer and supporting USPSTF recommendations[9]; and

Whereas, the Affordable Care Act links USPSTF recommendations, which currently conflict with those of the Alaska Tribal Health System and Alaska Native Epidemiology Center), and insurance coverage requirements, which may lead to denial of medically appropriate colorectal cancer screening in Alaskan Native patients[10]; and

Whereas, intensified efforts at the local, state, tribal, and federal level will be necessary to reduce the burden of early-onset colorectal cancer among Alaskan Natives, both living in and relocated out of Alaska, and the greater American public; and

Whereas, recommendations focused specifically on the Alaskan Native population with regards to colorectal cancer screening are not in conflict with the USPSTF position on colorectal screening in average-risk adults; and

Whereas, a quality evaluation of all rural and urban-setting colonoscopies conducted as part of the Alaska Native Tribal Health Center Colorectal Cancer Control Program funded by the U.S. Centers for Disease Control and Prevention from 2009 to 2015 (n = 6,704) reported comparable complication rates to the general U.S. population (0.5%)[7]; and

Whereas, colonoscopy is the preferred modality for colorectal cancer screening due to a high number of false-positive results associated with a high prevalence of Helicobacter pylori-associated hemorrhagic gastritis in the Alaskan Native population[7]; and

Whereas, greater investment in colorectal cancer prevention and control efforts may eventually lead to reduced mortality and population-level cancer stage migration; therefore be it

RESOLVED, that our American Medical Association advocates that the National Cancer Institute dedicate resources to the investigation of early-onset colorectal cancer in Americans younger than age 45 (Directive to Take Action); and be it further

RESOLVED, that our AMA will coordinate with interested national medical specialty societies, state medical associations, Alaska Native Corporations, and tribal governments to enhance physician education and awareness of the tribal public health authority recommendation to initiate preventive screening for colorectal cancer at age 40 in individuals with Alaska Native ancestry and advocate that these screenings be covered by all public and private payers, including the Indian Health Service and U.S. Centers for Medicare and Medicaid Services. These patients should also be counseled that the U.S. Preventive Services Task Force does not have a position on initiating colorectal cancer screening at age 40 in the Alaska Native population, and thus should be presented the risks and benefits associated with colonoscopy and medically appropriate screening alternatives. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

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RELEVANT AMA POLICY

Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA D-425.990

Our American Medical Association will coordinate with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45.

Clinical Preventive Services H-410.967

1. Our American Medical Association recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter.
2. Our AMA will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available.
3. Our AMA will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of non-reservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-26)

Introduced by: American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Subject: Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality

Referred to: Reference Committee D

Whereas, since 2020 there has been a 12% decrease in labor and delivery units in rural hospitals, with fewer than half of United States counties offering labor and delivery services and more than two closures per month over the last four years, according to the Center for Healthcare Quality and Payment Reform (CHQPR)[1]; and

Whereas, many additional rural hospitals are at risk of losing maternity care services due to financial losses associated with maintaining 24/7 staffing compared to reimbursement, with CHQPR estimating that more than 100 additional closures may occur in 2026[1]; and

Whereas, rural hospitals are at even greater risk of closure due to reductions in Medicaid and Affordable Care Act funding following enactment of H.R.1 in 2025; and

Whereas, birthing individuals in maternity care deserts, rural counties, and communities predominantly composed of American Indian and Alaska Native individuals experience extended travel distances and times to obtain maternity services, increasing the risk of preterm birth and out-of-hospital delivery; and

Whereas, closure of labor and delivery units places systemic strain on emergency medical services, medical transport services, and emergency rooms in hospitals without maternity care physicians, and life-threatening obstetric complications may occur in these settings; and

Whereas, over 80% of maternal deaths are preventable with appropriate prenatal, labor and delivery, and postpartum care;[3] and

Whereas, 60% of maternal deaths occur in the postpartum period (up to 12 months after birth,) the majority related to cardiovascular disease or behavioral health;[3] and

Whereas, there is a parallel between states with abortion restrictions and states with poor maternal health outcomes;[4] and

Whereas, rural communities experience significantly higher maternal mortality rates overall, and more than 70% of these deaths occur during the postpartum period;[5] and

Whereas, a 2023 study in the American Journal of Public Health reported that pregnant individuals residing in rural areas experience higher risk of ICU admission, and nearly twice the maternal mortality of those in urban areas;[6] therefore be it

RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period (Directive to Take Action); and be it further

RESOLVED, that our AMA ensure that this report includes evidence-based recommendations to reduce preventable maternal mortality through the postpartum year, including strategies for optimized allocation of federal and state funding (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with specialty societies and public health stakeholders to promote and disseminate innovative practice models—such as regional call-sharing systems, tele–maternal-fetal medicine support, and hospital–physician partnership structures—designed to reduce rural maternal morbidity and mortality, including during the postpartum period. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

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RELEVANT AMA POLICY

H-420.946 (2024) Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access

D-420.993 (2021) Disparities in Maternal Mortality

H 420.993 (2024) Improving Mental Health Services During Pregnancy and Postpartum

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Eliminate PFAS and Glyphosate in our Food and Environment

Referred to: Reference Committee D

Whereas, the EPA in 2025 has allowed PFAS insecticides for use on US food crops (e.g. isocycloseram (insecticide) and cyclobutrifluram (fungicide), and these compounds are linked to serious health issues, including liver toxicity, cancer, and reproductive harm[1]; and

Whereas, PFAS do not break down easily, remain on the food crops, and contaminate both the soil and the water supply indefinitely endangering both human and environmental health[2]; and

Whereas, recently the US by presidential order is expanding and allowing glyphosate to be used on our food supply despite health warnings[3]; and

Whereas, Glyphosate has serious health risks including non-Hodgkin lymphoma, liver disease, metabolic disorders, and hormone disruption, with studies indicating neurotoxicity, developmental effects, and increased cancer risk by up to 41%[4, 5]; and

Whereas, the AMA has policy for PFAS danger to human health[6]; therefore be it

RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating for removal of PFAS and Glyphosate chemicals from our food supply and environment. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

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6. H-135.916

RELEVANT AMA POLICY

H-135.916 Per- and Polyfluoroalkyl Substances (PFAS) and Human Health

1. Our American Medical Association supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health.
2. Our AMA supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances.
3. Our AMA will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.
4. Our AMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts. [Res. 901, I-19 Modified: Res. 428, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Light Pollution

Referred to: Reference Committee D

Whereas, the current AMA policy on adverse human health effects and environmental damage of light pollution and high blue wavelength is based on a Council on Science and Public Health (CSPH) report from 2012: (Report 4 of the CSPH (a-12) Light Pollution: Adverse Health Effects of Nighttime Lighting[1]; and

Whereas, AMA policy on disability glare remains intact and widely adopted from Resolution 516, A-09[2]; and

Whereas, the AMA policy on LED outdoor lighting is based on a CSPH report from 2016 CSAPH Report 2-A-16: Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting[3]; and

Whereas, these documents remain as the AMA advice for nighttime lighting for communities and cities worldwide, and are frequently downloaded and used as expert opinion for many local towns and cities worldwide[4]; and

Whereas, significant new research and evidence have been reported over the past 10 years, we should now update our AMA policy on light at night and excess blue light night time emission[0]; and

Whereas, the suppression of melatonin from excess blue light wavelength especially at 479 nm as reported by Martin Moore-ede in “The Light Doctor” 2024 leads to numerous adverse human health effects well documented by many and numerous scientific publications, including in JAMA[5, 6, 9, 10]; and

Whereas, our current AMA policy from 2016 states outdoor lighting should be 3000K or less, that recommendation is outdated now, and many lighting companies continue to recommend 3000K outdoor lighting or even still 4000K in some cases[3]; and

Whereas, night street light dimming capabilities are now readily available and should be encouraged for minimal added cost per light fixture, for dimming streetlights late at night a time of a towns choosing that will further limit glare, further save energy usage during late night and early morning lighting times[7]; and

Whereas, significant advances in LED technology has been made, with 2700K lighting now readily available, and even 2200K or 2400K lighting now offered, with significantly lower blue light emission[8]; therefore be it

RESOLVED, that our American Medical Association update its outdoor lighting recommendations to be:

1. Most outdoor lighting including street lighting should be 2700K or lower
2. Exceptions for inner city high traffic regions could be made for 3000K when deemed necessary for public safety
3. For rural and residential areas, or locations with interest in environmentally friendly policy, strong considerations be given to use 2200K to 2400K outdoor lighting
4. AMA policy on shielding to prevent disability glare should remain unchanged and should have fully shielded light fixtures to limit emission to 10 degrees below the horizontal to limit glare
5. Consideration should be given for streetlight dimming technology on most streetlights for further energy savings at low traffic times and further glare reduction. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

REFERENCES

1. H-135.932
   CSAPH Rep. 4, A-12, reaffirmation CSPH Rep 1, A-22, Reaffirmation: BOT Rep 30, A-24
2. H-135.937
   Res. 516, A-09, Reaffirmed: CSAPH Rep. 4, A-12, Reaffirmed: CSAPH Rep. 1, A-22
3. CSAPH Rep. 02, A-16
4. Multiple citations in journals worldwide
5. AMA Journal of ethics, Oct 2024, Vol 26, N10: E804-810, "We're all Healthier Under a Starry Sky", Mario Motta, MD
6. *The Light Doctor: Using Light to Boost Health, Improve Sleep, and Live Longer, Martin Moore-ede, Circadian books 2024*
7. https://www.microchip.com/en-us/solutions/sustainability/street-lighting
8. https://americanelectriclighting.acuitybrands.com/products/family/autobahn-led-cobra-head
9. New Insights on Circadian Health and Cardiometabolic Disease-Light, Sleep, Food, Exercise, and More, JAMA 2025;334;(23):2055-2057. doi:10.1001/jama.2025.22365
10. Role of Circadian Health in Cardiometabolic Health and Disease Risk: A Scientific Statement From the American Heart Association, Circulation
    Volume 152, Number 21

RELEVANT AMA POLICY

H-135.932 Light Pollution: Adverse Health Effects of Nighttime Lighting

1. Our American Medical Association supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Our AMA recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Our AMA supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. Our AMA supports work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. [CSAPH Rep. 4, A-12Reaffirmation: A-22Reaffirmed: CSAPH Rep. 1, A-22Reaffirmed: BOT Rep. 30, A-24]

H-135.937 Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings

1. Our American Medical Association will advocate that all future outdoor lighting be of energy efficient designs to reduce waste of energy and production of greenhouse gases that result from this wasted energy use.
2. Our AMA supports light pollution reduction efforts and glare reduction efforts at both the national and state levels.
3. Our AMA supports efforts to ensure all future streetlights be of a fully shielded design or similar non-glare design to improve the safety of our roadways for all, but especially vision impaired and older drivers. [Res. 516, A-09 Reaffirmed: CSAPH Rep. 4, A-12 Reaffirmed: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-26)

Introduced by: American Academy of Ophthalmology

Subject: Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control

Referred to: Reference Committee D

Whereas, uncorrected myopia (nearsightedness) is the leading cause of distance vision impairment globally; and

Whereas, myopia continues to increase among children worldwide and is projected to affect up to 50% of the world's population by 2050 with high myopia in 10%; and

Whereas, myopia and especially high myopia is associated with increased risk of serious ocular complications such as retinal detachment, myopic maculopathy, glaucoma, and choroidal neovascularization, which represent avoidable causes of visual impairment if myopia progression can be slowed; and

Whereas, peer-reviewed evidence demonstrates that interventions such as environmental/behavioral changes (e.g., increased outdoor time, reducing near work/excessive screen time), optical interventions (e.g., highly aspherical lenses, peripheral defocus contact lenses), and pharmacological treatment (e.g., low dose atropine drops) can slow the progression of myopia in children and adolescents, with other promising treatments under evaluation; and

Whereas, public awareness of myopia as a progressive condition and of the availability of these evidence-based interventions to reduce myopia progression remains limited, contributing to underutilization and preventable long-term morbidity; and

Whereas, despite its significant impact on health and morbidity, myopia is not consistently classified as a disease, including by the Centers for Medicare and Medicaid Services; and

Whereas, inconsistent insurance coverage for these evidence-based myopia-control treatments creates financial barriers for patients seeking early intervention, disproportionately affecting underserved populations; therefore be it

RESOLVED, that our American Medical Association recognize that myopia is a significant and increasing public health concern warranting public health outreach, improved screening in children, and prevention efforts (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for public education initiatives to increase awareness among patients, caregivers, educators, and policymakers about the risks of progressive myopia and the availability of evidence-based interventions shown to slow myopia progression (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to formally classify myopia as a disease to ensure that patients can receive appropriate treatment and insurance coverage for the treatment of this medical condition (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to ensure comprehensive insurance coverage and reimbursement for evidence-based treatments demonstrated to slow myopia progression in pediatric and adolescent patients. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

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2. Saw SM, Matsumura S, Hoang QV. Prevention and Management of Myopia and Myopic Pathology. Invest Ophthalmol Vis Sci. 2019 Feb 1;60(2):488-499. doi: 10.1167/iovs.18-25221. PMID: 30707221.
3. Lanca C, Pang CP, Grzybowski A. Effectiveness of myopia control interventions: A systematic review of 12 randomized control trials published between 2019 and 2021. Front Public Health. 2023 Mar 23;11:1125000. doi: 10.3389/fpubh.2023.1125000. Erratum in: Front Public Health. 2024 Sep 25;12:1460156. doi: 10.3389/fpubh.2024.1460156. PMID: 37033047; PMCID: PMC10076805.
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5. Pan W, Morgan I, Flitcroft I, Rose K, Ostrin LA, Rosenfield M, Govender-Poonsamy P, Siu-Villaseñor D, Kaymak H, Khew JM, Woo O, Tsubota K, Shinde L, Prenat O, Ma J, Qu J, Yang Z, Wang Y, Tan KO, Davis A, Lan W. The need to address the myopia pandemic: summary report of the global myopia public health summit 2024. Glob Health Res Policy. 2025 Sep 23;10(1):45. doi: 10.1186/s41256-025-00445-7. PMID: 40983945; PMCID: PMC12455837.

RELEVANT AMA POLICY

H-60.913 Increasing Outdoor Activity to Prevent Myopia Onset and Progression in School Children
Our AMA supports efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children. [Res. 405, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-26)

Introduced by: New York

Subject: Guiding Principles of Pandemic Prevention, Preparedness and Response; Support for the World Health Organization Pandemic Agreement

Referred to: Reference Committee D

Whereas, Resolution WHA78.1, the “WHO Pandemic Agreement” was adopted at the Seventy-eighth World Health Assembly on May 20th, 2025; and

Whereas, the WHO Pandemic Agreement was negotiated, and subsequently adopted by 193 out of the 194 member states, with the sole exception being the United States of America; and

Whereas, on January 22nd, 2026, the United States of America withdrew its membership from the World Health Organization; and

Whereas, New York State and many other states were gravely affected by the COVID-19 Pandemic, and should uphold the highest level of scientific, medical and intergovernmental evidence and cooperation for the prevention, preparedness and response to future pandemics; and

Whereas, State level policies such as Medical Society of the State of New York’s “MSSNY Principles of Public Health During an Infectious Disease Outbreak” (260.875) have been a useful initial resource for guiding Pandemic Prevention, Preparedness and Response, but are not as extensive as the principles stated in the WHO Pandemic Agreement; and

Whereas, National level policies such as the American Medical Association’s “Pandemic Preparedness” (H-440.847), “Pandemic Ethics and the Duty of Care” (D-130.960), “AMA Role in Addressing Epidemics and Pandemics” (H-440.835)722, “Low Cost Drugs to Economically Disadvantaged Countries During Times of Pandemic Health Crises” (H-250.988) and “Pandemic Ethics and the Duty of Care” (H-140.821), speak to federal level guidance and limited international guidance, they do not speak to several more in-depth principles of pandemic preparedness regarding intergovernmental and international cooperation that is called for in the WHO Pandemic Agreement; and

Whereas, the American Medical Association is a member of the World Medical Association, and specific policy supporting the below guiding principles from the World Health Organization Pandemic Agreement would allow the American Medical Association to participate in debate and policy making in a more evidence-based way, given the present lack of commitment to these principles from the United States Federal Government; therefore be it

RESOLVED, that our American Medical Association support and adopt the following Articles of the World Health Organization Pandemic Agreement as our framework for Pandemic Prevention, Preparedness and Response:

Article 4, Pandemic prevention and surveillance;

- Article 5, One Health approach for Pandemic Prevention, Preparedness and Response;
- Article 6, Preparedness, readiness and health system resilience;
- Article 7, Health and care workforce;
- Article 8, Regulatory systems strengthening;
- Article 9, Research and development;
- Article 10, Sustainable and geographically diversified local production;
- Article 11, Transfer of technology and cooperation on related know-how for the production of pandemic-related health products;
- Article 12, Pathogen Access and Benefit-Sharing Systems;
- Article 13, Supply chain and logistics;
- Article 14, Procurement and distribution;
- Article 15, Whole-of-government and whole-of-society approaches;
- Article 16, Communication and public awareness;
- Article 17, International cooperation and support for implementation;
- Article 18, Sustainable financing; and be it further.

(Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Erosion of the Public Evidence Base for Health Policy

Referred to: Reference Committee D

Whereas, for many decades, the U.S. Centers for Disease Control and Prevention (CDC) have maintained surveillance systems for a wide range of diseases and other conditions to help guide public and private efforts to protect the health of all Americans and, in some cases, global health; and

Whereas, for almost all such diseases and conditions, the decision to monitor each one is based on the professional judgment of experts in the field and committees of outside experts and approved at an annual meeting where each states epidemiologist is represented; and

Whereas, for each of the diseases and conditions in this surveillance system, a decision for surveillance is based on consideration of the condition's public health importance, the utility of a surveillance system to guide disease control efforts, and – in some cases – the prospects for eliminating the disease or condition permanently; and

Whereas, experts predict that declining vaccination rates and other risk factors will lead to dramatic increases in vaccine-preventable disease morbidity, which must be promptly tracked, analyzed, and controlled in order to prevent further morbidity and mortality; and

Whereas, we are seeing the resurgence of vaccine-preventable disease such as pertussis[1], Haemophilus influenzae[2], and Neisseria meningitisi[3] in the United States; and

Whereas, CDC surveillance data from the 2024–2025 influenza season documented at least 43 million symptomatic illnesses, 560,000 hospitalizations, and 38,000 deaths, making it the most severe influenza season since 2017–2018 and underscoring the necessity of uninterrupted national surveillance systems to guide timely response[4]; and

Whereas, an audit published in Annals of Internal Medicine found that 46% of CDC databases previously updated at least monthly had halted updates by October 2025, with most pauses exceeding six months[5,6]; and

Whereas, the same audit found that paused databases disproportionately involved vaccination-related surveillance, including influenza, COVID-19, and RSV, while none of the currently updated databases covered vaccination topics[7]; and

Whereas, these pauses were unexplained, with no public notices, banners, or press releases provided by the CDC to justify or contextualize the interruptions[8]; and

Whereas, the Annals investigation warns that these widespread interruptions undermine evidence-based medicine, impede outbreak readiness, and erode public trust in federal public health leadership at a time when accurate information is crucial; and

Whereas, this pause appears to have been initiated solely at the federal level, without consultation with state, city, territorial, or other entities who also have responsibility for communicable and chronic disease control; and

Whereas, as of April 2026, the United States faces a prolonged respiratory syncytial virus (RSV) season[9]; and

Whereas, the convergence of paused surveillance, budget reductions, political interference, and declining childhood vaccination rates significantly endangers national health security; therefore be it

RESOLVED, that our American Medical Association urges the U.S. federal government to publicly disclose the causes of federal disease surveillance interruptions; to provide expeditious timelines for restoration of surveillance databases and analyses for all nationally notifiable diseases, including hiring and re-hiring of scientifically qualified and appropriately funded staff; and to adopt an adequate mandatory public notification protocol for any future pauses (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate Congressional oversight, including an annual report, assessing CDC surveillance performance; staffing adequacy; data transparency; and the impact of funding levels collectively on public health readiness and national security. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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3. https://www.cdc.gov/meningococcal/php/surveillance/index.html
4. CDC Releases 2024-2025 Flu Report, With Suggestions for Upcoming Season | Infectious Diseases | JAMA | JAMA Network
5. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
6. Nearly half of CDC surveillance databases have halted updates, raising concerns about health data gaps
7. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
8. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
9. RSV is still spreading, prompting states to extend the immunization period | CNN

RELEVANT AMA POLICY

Public Health Surveillance H-440.813
Bolstering Public Health Preparedness H-440.892
Vector-Borne Diseases H-440.820
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Restoring Balanced Scientific Perspective within the ACIP

Referred to: Reference Committee D

Whereas, in June 2025, our AMA adopted an emergency resolution, now codified as AMA Policy D-440.902, expressing alarm about then-recent developments in United States vaccine policy; and

Whereas, in July 2025, multiple medical specialty associations and public health organizations filed a lawsuit that among other issues argued that the voting members appointed in 2025 to the Advisory Committee on Immunization Practices (ACIP) panelists lacked the qualifications to recommend vaccinations and that their decisions endangered the health of Americans; and

Whereas, the undermining of United States vaccine and public health policy by Health and Human Services Secretary Robert F. Kennedy Jr. has continued and worsened since June 2025; and

Whereas, lapses in vaccine coverage for many vaccines result in preventable harm to vulnerable persons who cannot be vaccinated or in whom vaccines are less effective, to persons in whom these vaccines are less effective than in others, and to people both near and far who deserve protection from preventable diseases; and

Whereas, in a factually rich and carefully balanced Memorandum and Order issued on March 16, 2026, Federal Judge Brian Murphy reversed the appointment of the new, largely unqualified ACIP members; stayed the decisions purportedly made by this panel; and stayed other vaccine-related decisions made by the U.S. Department of Health and Human Services (HHS) and the U.S. Centers for Disease Control and Prevention (CDC) without consulting any version of the ACIP[1]; and

Whereas, Federal law specifies that, “Advisory committees requiring technical expertise should include persons with demonstrated professional or personal qualifications and experience relevant to the functions and tasks to be performed by the Committee[2]; and

Whereas, on April 6, 2026, HHS published in the federal register and published on CDC webpages changes to the ACIP Charter on membership of the voting members of the ACIP, moving from topical coverage to specialty area and geographical coverage, and changing the purpose and composition of ACIP[3]; and

Whereas, geographic representation cannot improve decision-making because the vaccine recommendations should apply nationwide to all individuals in similar circumstances, because Americans and their infections travel frequently and migrate from one region to another, and because regional population-level variations in the immunization schedule would complicate vaccine compliance determinations without any corresponding benefit; and

Whereas, this new charter appears intended to thwart physicians' claims for organizational-level relief from counterproductive and burdensome changes to physicians' counseling workload and to the difficulty of achieving community vaccine coverage; and

Whereas, this new charter eliminates the prior specification for experience in preventive medicine and health economics, among others[4]; and

Whereas, the proposed new ACIP charter, published on April 6, 2026, was not available for public comment as of April 10, 2026; therefore be it

RESOLVED that our American Medical Association amend Policy D-440.902 by addition and deletion to read as follows:

1. Our American Medical Association will continue~~initiate~~ sustained public advocacy in support of the ~~current~~previous Advisory Committee on Immunization Practices (ACIP) structure, including the liaison representative program, as outlined in ACIP's 2024 Charter and practiced until Spring 2025.
2. Our AMA will ~~immediately send a letter to the Secretary of Health and Human Services calling for an immediate reversal of the recent changes to the Advisory Committee on Immunization Practices~~ pursue all appropriate channels to reverse the 2025-2026 changes to ACIP's structure, membership, and operations.
3. Our AMA will ~~immediately send a letter to the Senate Committee on Health, Education, Labor, and Pensions (HELP) and~~ request an investigation into the actions of the U.S. Secretary of Health and Human Services regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.
4. Our AMA will continue to identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA condemns the arbitrary and unilateral 2026 alterations to the ACIP charter, which appear to have been designed to subvert the authority of relevant Federal judges and to allow the appointment of unqualified committee members and liaisons to the Advisory Committee on Immunization Practices (ACIP) (New HOD Policy); and be it further

RESOLVED, that our AMA will collaborate with interested state and specialty societies to support litigation against changes to the ACIP charter, budget, operating principles and staffing which produce ongoing harm to the public's health, and many of which were adopted without adequate and meaningful opportunity for public comment (Directive to Take Action); and be it further

RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the most recent update of the charter. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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2. 41 CFR 102-3 60(b)(1)
3. https://www.federalregister.gov/documents/2026/04/06/2026-06577/advisory-committee-on-immunization-practices-acip-notice-of-charter-renewal, accessed April 14, 2026
4. https://perma.cc/WVL8-XJWH

RELEVANT AMA POLICY

Advisory Committee on Immunization Practices D-440.902
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-26)

Introduced by: Colorado, Washington, Utah, American College of Physicians

Subject: Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions

Referred to: Reference Committee D

Whereas, our American Medical Association supports the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people; and

Whereas, our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals; and

Whereas, our American Medical Association supports initiatives to promote environmental sustainability and other efforts to halt global climate change; and

Whereas, the AMA's Declaration of Professional Responsibility identifies among physician "duties and responsibilities", to "Educate the public and polity about present and future threats to the health of humanity" and to "Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being"; and

Whereas, the endangerment finding is a conclusion by the U.S. Environmental Protection Agency (EPA) that certain greenhouse gases, such as carbon dioxide and methane, pose a threat to public health and welfare, allowing for federal regulation of these emissions under the Clean Air Act and has been a key legal basis for regulating greenhouse gas emissions; and

Whereas, on 2/12/2026, the EPA announced it had repealed the endangerment finding; and

Whereas, it is likely that multiple lawsuits to restore the endangerment finding will be filed; therefore be it

RESOLVED, that our American Medical Association encourage the Litigation Center to monitor lawsuits against the rescinding of the endangerment finding and to consider submitting amicus curiae briefs in those with a likelihood of success on behalf of the HOD (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against the repeal of the endangerment finding and support its restoration (Directive to Take Action); and be it further

RESOLVED, that our AMA publicly state that repeal of the endangerment finding is a threat to public health and take appropriate action, to include collaboration with relevant associations and stakeholders, to ensure that the public is adequately educated. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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2. https://www.epa.gov/newsreleases/president-trump-and-administrator-zeldin-deliver-single-largest-deregulatory-action-us
3. https://www.scientificamerican.com/article/what-repealing-the-endangerment-finding-means-for-public-health/
4. https://www.nytimes.com/2026/02/12/climate/what-to-know-epa-endangerment-finding.html
5. https://woods.stanford.edu/news/epa-endangerment-finding-explained-5-facts-about-science-and-health-risks

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938
AMA Advocacy for Environmental Sustainability and Climate H-135.923
Declaring Climate Change a Public Health Crisis D-135.966

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-26)

Introduced by: American Society for Clinical Pathology, American Society of Cytopathology, American Society of Dermatopathology, College of American Pathologists, National Association of Medical Examiners

Subject: Clinical Laboratory Workforce Shortage and Sustainability

Referred to: Reference Committee D

Whereas, medical laboratory professionals working in multiple disciplines throughout clinical, anatomic, and public health laboratories are indispensable, highly trained, and specialized members of the physician-medical director led health care team which generates critical diagnostic information that drives the majority of medical decisions across all clinical specialties; and

Whereas, the United States is experiencing a critical and worsening shortage of qualified clinical laboratory personnel due to workforce attrition, retirements, limited training program capacity, and insufficient recruitment, training only one third to one half of needed positions annually; and

Whereas, inadequate staffing in clinical laboratories can lead to delays in results, increased diagnostic errors, reduced access to specialized testing, and degraded quality of care, ultimately resulting in significant negative impacts on patient outcomes; and

Whereas, barriers to entering and remaining in the clinical laboratory workforce include limited awareness of the profession, insufficient compensation relative to educational requirements, lack of career advancement opportunities, and regulatory and reimbursement challenges; therefore be it

RESOLVED, that our American Medical Association recognize the unique and critical role of medical laboratory professionals in patient care and public health and the urgent need to address workforce shortages (New HOD Policy); and be it further

RESOLVED, that our AMA support advocacy efforts to sustain and strengthen clinical laboratory training and education programs, including assistance for faculty development and infrastructure, to address capacity and recruitment needs (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, educational institutions, health care organizations, and professional societies, to promote awareness of clinical laboratory careers, as members of the physician-led health care team, among students and the public. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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2. The United States is facing a critical, long-term shortage of medical laboratory professionals, with the Bureau of Labor Statistics (.gov) projecting a need for roughly 10,000–24,000 new professionals annually to fill vacancies, far exceeding the ~5,000–7,400 annual graduates. Bureau of Labor Statistics, US Department of Labor, https://www.bls.gov/ooh/healthcare/clinical-laboratory-technologists-and-technicians.htm
3. AACC Whitepaper on Overcoming Lab Staffing Shortages, Erika Deaton-Mohney MT(ASCP), CPP; Sharon Ehrmeyer, PhD, MT(ASCP); Christopher Farnsworth, PhD, DABCC; Theresa Kunzler, MS, MT(ASCP); Frederick Strathmann, PhD, DABCC; & Monica Thomas, MPA, CLS(ASCP); https://myadlm.org/advocacy-and-outreach/adlm-policy-reports/2023/adlm-whitepaper-on-overcoming-lab-staffing-shortages#:~:text=The%20mechanism%20by%20which%20many,to%20reference%20laboratories%20(25)
4. Edna Garcia, Jenny Diaz, Iman Kundu, Melissa Kelly, Ryan Soles, The American Society for Clinical Pathology 2024 Vacancy Survey of medical laboratories in the United States, American Journal of Clinical Pathology, Volume 164, Issue 5, November 2025, Pages 759–777, https://doi.org/10.1093/ajcp/aqaf101

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-26)

Introduced by: American College of Occupational & Environmental Medicine

Subject: Respiratory Protection for Wildland Firefighters

Referred to: Reference Committee D

Whereas, wildland firefighters are exposed to wildfire smoke containing fine particulate matter (PM2.5), carbon monoxide, aldehydes, benzene, acrolein, dioxins, and polycyclic aromatic hydrocarbons at levels linked to acute and chronic cardiopulmonary harm and cancer, yet most wildland fire suppression operations do not require respiratory protection; and

Whereas, federal interagency guidance has historically excluded mandatory respirator use during suppression, citing concerns related to heat burden and performance, despite evidence supporting the effectiveness of National Institute for Occupational Safety and Health (NIOSH)-approved filtering facepiece respirators, air-purifying respirators (APRs), and powered air-purifying respirators (PAPRs); and

Whereas, bandannas and non-certified masks provide no meaningful protection, while properly selected, fit-tested, and medically cleared respirator use can significantly reduce toxic inhalation risks in both wildland and wildland–urban interface (WUI) operations; and

Whereas, federal wildland firefighters now receive enhanced workers' compensation under the Federal Employees' Compensation Act (FECA) for certain cancers, chronic obstructive pulmonary disease, and sudden cardiac events, while many state, county, municipal, and volunteer firefighters face inconsistent presumptive coverage that may exclude smoke-related injuries; and

Whereas, NIOSH and peer-reviewed research confirm health risks from recurrent wildfire smoke exposure and emphasize the value of systematic health monitoring and respiratory protection for firefighters; and

Whereas, the most current edition of the National Fire Protection Association (NFPA) 1984 standard, developed with direct NIOSH participation, establishes performance standards for wildland firefighter respirators that address particulate, carbon monoxide, and toxic gas exposures while requiring heat resistance, storage integrity, and IP65 protection for powered units; therefore be it

RESOLVED, that our American Medical Association advocate for the adoption of evidence-based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to NFPA 1984-compliant, NIOSH-approved Class 2 or Class 3 respirators, and protocols that balance respiratory protection with heat and exertion demands (Directive to Take Action); and be it further

RESOLVED, that our AMA join the American College of Occupational and Environmental Medicine (ACOEM) in advocating for relevant federal and state fire agencies, forestry departments, and occupational safety organizations to research, develop, and field-test

lightweight, low-breathing-resistance (<=80 mm H_2O at 150 L/min) respirators and related controls better suited for prolonged wildland use (8 or more hours) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the creation of surveillance and longitudinal medical monitoring programs for wildland firefighters to support registries and studies evaluating respiratory protection effectiveness, acute and chronic health risks, and mitigation strategies. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-440.810: Availability of Personal Protective Equipment (PPE)

1. Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

[Res. 412, I20: Appended: Res. 414, A21: Modified: Res. 401, I-21]

H-440.813 Public Health Surveillance

1. Our American Medical Association recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats.

2. Our AMA recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities.
3. Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health.
4. Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data.
5. Our AMA supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws.
6. Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.
7. Our AMA will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.
8. Our AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments.
9. Our AMA supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.

[CSAPH Rep. 1, I-19: Reaffirmed: Res. 219, A-21: Appended: Alt. Res. 402, A-21: Modified: CSAPH Rep. 2, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-26)

Introduced by: Women Physicians Section

Subject: Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault

Referred to: Reference Committee D

Whereas, it is estimated that 1.2 million people in the United States are living with HIV, yet about 1 in 8 people do not know they have the disease[1]; and

Whereas, the CDC reported that 56% of new HIV diagnoses in 2022 were amongst people aged 13-24 years old[2]; and

Whereas, post-exposure prophylaxis (PEP) uses antiretroviral (ARV) medications to reduce the risk of human immunodeficiency virus (HIV) transmission when initiated within 72 hours of exposure[3]; and

Whereas, completion of a full 28-day HIV post-exposure prophylaxis (PEP) regimen is recommended to maximize effectiveness in preventing HIV infection[3]; and

Whereas, individual studies demonstrate variable uptake and completion rates, including acceptance rates near 59–62% in some settings and completion rates ranging from approximately 29% to 66% across cohorts[4,5,6,7]; and

Whereas, strategies such as dispensing medication before discharge, providing trauma-informed counseling, and ensuring coverage of the full PEP regimen have been identified as mechanisms to improve adherence and reduce barriers[3]; and

Whereas, financial barriers, insurance status, trauma-related decision-making challenges, and logistical barriers contribute to failure to initiate or complete prescribed PEP regimens[1,4,5,6]; and

Whereas, up to 69% of sexual assault survivors are between the ages of 12-34 years of age[10]; and

Whereas, survivors of sexual assault may be exposed to HIV, with estimated per-act transmission risks of approximately 0.1–0.2% for vaginal assault and 1–3% for anal assault when assailant HIV status is unknown, and trauma or concurrent sexually transmitted infections may increase transmission risk[8,9]; and

Whereas, sexual assault survivors experience some of the lowest PEP completion rates among exposure groups, with approximately 40% completing a full regimen in meta-analysis studies and substantially lower completion documented in some U.S. cohorts[3,4]; and

Whereas, sexual contact through unprotected intercourse with an infected partner remains the most common method of HIV spread[11]; and

Whereas, although HIV transmission after sexual assault is relatively uncommon, documented seroconversions have occurred and longitudinal studies demonstrate increased HIV acquisition risk among sexual assault survivors compared with unexposed populations[9,12,13]; and

Whereas, women account for approximately 18–19% of new HIV diagnoses in the United States, with persistent racial disparities disproportionately affecting Black women, underscoring the importance of equitable access to HIV prevention strategies following sexual assault[14]; and

Whereas, some jurisdictions, including New York State, now require hospitals to provide a full 28-day HIV PEP regimen to sexual assault survivors to reduce structural barriers to completion[15]; therefore be it

RESOLVED, that our American Medical Association encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault (New HOD Policy); and be it further

RESOLVED, that our AMA amend H-20.900 "HIV, Sexual Assault, and Violence" as follows:

> Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at recommended intervals consistent with current clinical guidelines if the initial test is negative, and that strict confidentiality of test results be maintained; and
>
> (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

8.1 Routine Universal Screening for HIV

Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.

(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.

(c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.

(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.

(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.

(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

[Issued: 2016]

H-20.920 HIV Testing

(1) General Considerations

a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;

b) HIV testing should be consistent with testing for other infections and communicable diseases;

c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;

d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;

e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing

a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a

voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if they refuse HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIVtesting without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.
(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.
(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
d) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results;
e) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.
(5) Routine HIV Testing
a) Routine HIV testing should include appropriate informed consent and pre-test and post-test counseling procedures;
b) State medical associations should work to create state laws that encourage hospitals and other medical facilities to initiate routine HIV testing programs; and
c) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.
(6) Opt-out HIV Testing
a) Opt-out HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually

transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.
(7) Mandatory HIV Testing
a) Our AMA opposes mandatory HIV testing of the general population;
b) Mandatory testing for HIV infection is recommended for (i) military personnel; (ii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;
d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.
(8) HIV Test Counseling
a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;
c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.
(9) HIV Testing of Health Care Workers
a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;
d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV.
(10) Counseling and Testing of Pregnant People for HIV
Our AMA supports the position that there should be universal HIV testing of all pregnant people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
(11) HIV Home Test Kits
a) Our AMA does not oppose HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;
b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies.
(12) College Students
Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
[CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10; Modified: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission
In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

(1) Given the prevalence and distribution of HIV infection among individuals in the United States, the potential for effective early treatment of HIV infection, and the significant reduction in perinatal HIV transmission with treatment of pregnant people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all individuals. The ideal would be for all people to know their HIV status before considering pregnancy.

(2) Universal HIV testing of all pregnant people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.

(3) The final decision about accepting HIV testing is the responsibility of the patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for patients and their infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the patient presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for pregnant people and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a pregnant person or their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the pregnant patient and their infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for patients presenting in labor and those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up

studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected pregnant people, should be maintained.
[CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-80.998 Sexual Assault Survivor Services
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
[Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17]

H-80.991 Coverage for Care for Sexual Assault Survivors
Our American Medical Association advocates for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.
[Res. 805, I-24]

H-20.900 HIV, Sexual Assault, and Violence
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
[CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-26)

Introduced by: Women Physicians Section, American College of Lifestyle Medicine

Subject: Examining the Impact of Circadian Disruption from Shift Work During Pregnancy

Referred to: Reference Committee D

Whereas, circadian rhythm is centrally regulated by the suprachiasmatic nucleus of the hypothalamus and entrained by environmental light-dark cyclic inputs, enabling coordination of hormonal secretion, metabolic function, and physiologic homeostasis;[1] and

Whereas, light exposure during nighttime hours can desynchronize timing signals between the suprachiasmatic nucleus and peripheral cellular circadian rhythms;[2] and

Whereas, emerging evidence in occupational health, sleep medicine, and obstetrics suggests associations between circadian disruption and resulting perturbed melatonin cycles during pregnancy and adverse maternal and fetal outcomes, although existing evidence remains heterogeneous;[3] and

Whereas, a meta-analysis published under American Journal of Obstetrics and Gynecology reported "very low" certainty evidence suggesting higher rates of miscarriage among pregnant women with fixed night shifts in comparison to pregnant women who worked day shifts;[4] and

Whereas, rotating shifts have an association with preterm delivery and gestational hypertension;[4] and

Whereas, studies have demonstrated associations between maternal shift work and adverse neonatal outcomes, including psychological and behavioral problems;[3] and

Whereas, the timing of labor onset is determined by multifactorial physiologic processes, including sleep disruption and synchronicity between circadian rhythms and light exposure in pregnant physicians, which warrants further study;[2] and

Whereas, there is currently limited consensus guidance on scheduling accommodations for pregnant physicians and other health care workers exposed to shift work, leading to variability in institutional policies; and

Whereas, evidence-informed guidance may help support physician well-being, maternal health, and workforce sustainability while maintaining continuity of patient care; therefore be it

RESOLVED, that our American Medical Association supports the study of the impact of circadian disruption from shift work during pregnancy, including implications for maternal and fetal health (New HOD Policy); and be it further

RESOLVED, that our AMA encourages dissemination of evidence-informed approaches to scheduling and workplace accommodations for pregnant individuals as appropriate based on the findings of a report on circadian disruption from shift work during pregnancy. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/2026

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RELEVANT AMA POLICY

H-420.960 Effects of Work on Pregnancy
Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.

1. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
2. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
3. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
4. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

[CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation, A-12; Modified: CSAPH Rep. 1, A-22]

H-405.947 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows
Our American Medical Association urges:
a. medical schools, and the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree.
b. residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning,

pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty.

c. medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.

Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.

Our AMA supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, medical trainees, and physician residents and fellows, regardless of gender or gender identity.

Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

[Res. 309, I-22; Modified: CME Rep. 01, I-23]

H-135.932 Light Pollution: Adverse Health Effects of Nighttime Lighting

1. Our American Medical Association supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Our AMA recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Our AMA supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. Our AMA supports work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

[CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmed: BOT Rep. 30, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-26)

Introduced by: Women Physicians Section

Subject: Expanding Support for Women Experiencing Homelessness

Referred to: Reference Committee D

Whereas, the rate of unsheltered homelessness among women has increased significantly more than men in recent years, especially among unhoused veterans, and over three-quarters of unhoused families are headed by women[1,2]; and

Whereas, women experiencing homelessness have higher rates of mortality, poor health, mental illness, substance use, victimization, and adverse birth outcomes, yet face reduced access to preventive, reproductive, specialty, and ongoing healthcare services[1-3,9]; and

Whereas, homelessness and associated distress is disproportionately experienced by people of color as well as LGBTQ+ populations, and nearly two-thirds of unhoused gay and transgender youth will attempt suicide[2-4]; and

Whereas, domestic violence is a leading cause of homelessness among women and families, with over half of LGBTQ survivors reporting homelessness as a result, yet referral rates to support services after positive screening remains low[2,6,7,8]; and

Whereas, homeless women who have experienced intimate partner violence are more likely to have medical and psychiatric conditions and less likely to access primary care compared to those who did not[2,6,7,8]; and

Whereas, the Violence Against Women Act, first enacted in 1994 and reauthorized in 2022 to protect survivors' access to safe housing and prevent housing discrimination, will be up for reauthorization again in 2027[11,12,13]; and

Whereas, women experiencing homelessness have high rates of chronic physical conditions, including asthma, anemia, bronchitis, hypertension, and ulcers, as well as mental health conditions, particularly substance use and depression[5,10]; and

Whereas, unhoused patients report provider bias, stigma, and disrespect as major barriers to care, often leading them to forgo needed services, compounded by insurance gaps, medication access challenges, and limited knowledge about where to seek care[2,3,5,10]; and

Whereas, programs such as Boston Healthcare for the Homeless, are establishing systems for trauma-informed, low-barrier care specifically for women at shelters and at female-only drop-in times, encompassing services from behavioral health to reproductive health to cancer screening, while providing a safe space to access therapeutic activities[14], therefore be it

RESOLVED, that our American Medical Association amend H-160.903 "Eradicating Homelessness" by addition and deletion as follows:

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of ~~homeless patients~~ individuals experiencing homelessness, including gender-specific health needs and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their

professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;

b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and

c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-160.903 Eradicating Homelessness

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically **homeless** through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.

2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-**homeless**.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the **Homeless** Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for **homeless** persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of **homeless** patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for **homeless** patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of **homeless** patients.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;
    b. supports the establishment of multidisciplinary mobile **homeless** outreach teams trained in issues specific to housing insecure individuals; and
    c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

[Res. 401, A-15 Appended: Res. 416, A-18 Modified: BOT Rep. 11, A-18 Appended: BOT Rep. 16, A-19 Appended: BOT Rep. 28, A-19 Appended: Res. 414, A-22 Appended: Res. 931, I-22 Reaffirmed in lieu of: Res. 205, A-23]

H-295.912 Education of Medical Students and Residents about Domestic Violence Screening
Our American Medical Association will continue its support for the education of medical students and residents on **domestic violence** by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. [Res. 303, I-96 Reaffirmed: CME Rep. 2, A-06 Reaffirmed: CME Rep. 01, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-26)

Introduced by: Georgia

Subject: Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States

Referred to: Reference Committee D

Whereas, inflammatory bowel disease (IBD), encompassing Crohn's disease and ulcerative colitis, is a chronic, relapsing condition that requires early and accurate diagnosis as well as ongoing disease monitoring, including colonoscopy, to assess inflammation, guide therapy, and prevent complications[1]; and

Whereas, patients with long-standing IBD represent a high-risk population compared to the general colorectal cancer screening population, given their increased risk of colorectal cancer and need for more frequent surveillance colonoscopies[2],[3]; and

Whereas, a nationwide cohort study analyzing over 1.7 million IBD-related hospitalizations (2016–2021) demonstrated significant racial and ethnic disparities in IBD outcomes, with Black patients experiencing higher hospitalization rates and increased risks of complications such as perianal abscess and rectal bleeding compared to White patients[4]; and

Whereas, these disparities persist after adjusting for socioeconomic and hospital-related factors, suggesting that systemic inequities in access to timely diagnosis, specialist care, and advanced therapies contribute to worse outcomes and increased healthcare utilization[4]; and

Whereas, minority and uninsured patients with IBD, particularly Black and Hispanic individuals, are less likely to receive advanced biologic or novel therapies and are more likely to be treated with corticosteroids and opioids, which are associated with increased complications and poorer long-term outcomes[5],[6]; and

Whereas, interruptions in biologic therapy, often due to insurance instability or delays in prior authorization, can lead to loss of response through development of antidrug antibodies, necessitating therapy changes and increasing the risk of disease flares, hospitalizations, and complications[4]; and

Whereas, the high cost of biologic therapies represents a major component of IBD-related healthcare expenditures, while restrictive payer practices such as step therapy and prior authorization further delay access to effective treatment[7]; and

Whereas, colonoscopy is essential for both diagnosis and colorectal cancer surveillance in patients with long-standing IBD, as recommended by the American College of Gastroenterology and American Gastroenterological Association[2],[3]; and

Whereas, increasing public and provider awareness of low-cost or no-cost colonoscopy programs and expanding access for uninsured patients with IBD may improve early detection, reduce disease progression, and decrease long-term healthcare costs[4]; therefore be it

RESOLVED, that our American Medical Association support the development and implementation of standardized, scalable referral and patient navigation pathways for each state — through collaboration with the American Gastroenterological Association, the American College of Gastroenterology, the American Society for Gastrointestinal Endoscopy, the Crohn's & Colitis Foundation, state and local Departments of Public Health, Federally Qualified Health Centers, safety-net health systems, and community-based organizations — to connect patients with inflammatory bowel disease to timely and affordable colonoscopy services for diagnosis and surveillance, leveraging existing colorectal cancer screening and navigation models (New HOD Policy); and be it further

RESOLVED, that our AMA support educational initiatives and resource dissemination, developed in collaboration with appropriate partners—including patient advocacy organizations, professional societies, and health systems—to increase awareness among physicians regarding documentation requirements for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) eligibility in patients with severe inflammatory bowel disease, in order to improve access to financial support and insurance coverage (New HOD Policy); and be it further

RESOLVED, that our AMA support policies that support nationwide efforts to expand equitable access to colonoscopy services for patients with inflammatory bowel disease and increase physician awareness of disability benefit eligibility as a mechanism to improve continuity of care and access to necessary medical services. (New HOD Policy)

Fiscal Note Minimal – less than $5,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-26)

Introduced by: LGBTQ+ Section, Washington State Medical Association, California Medical Association

Subject: Expanding Access to High Resolution Anoscopy

Referred to: Reference Committee D

Whereas, Anal cancer incidence is markedly elevated among people living with HIV and other high-risk populations, including men who have sex with men, transgender women, individuals with prior vulvar high-grade squamous intraepithelial lesions (HSIL) or vulvar cancer, and solid organ transplant recipients, with incidence among men who have sex with men living with HIV approaching 89 per 100,000 person-years—more than tenfold higher than the general U.S. population[1]; and

Whereas, the ANCHOR trial demonstrated that treatment of anal HSIL reduces progression to anal cancer by 57%, establishing high-resolution anoscopy (HRA) with treatment as an evidence-based cancer prevention strategy[1]; and

Whereas, access to HRA in the United States is severely limited and geographically concentrated, with fewer than 200 HRA sites nationwide, nearly half located in five states (California, New York, Florida, Maryland, and Massachusetts), 17 states without any HRA site, several states with only a single site, and most services clustered in urban academic centers[2]; and

Whereas, national estimates indicate that more than 120,000 people living with HIV with abnormal screening results lack access to follow-up HRA through their HIV care facility, creating substantial disparities in cancer prevention access for rural, low-income, and marginalized populations[3]; and

Whereas, HRA services in the United States are variably housed across multiple specialties—including infectious diseases, colorectal surgery, obstetrics/gynecology, and others—and there is no uniformly standardized graduate medical education pathway or accreditation requirement for competency in HRA; international practice standards have emphasized the need for defined minimum competencies and formalized training evaluation, and existing certification programs reflect the substantial procedural experience required for proficiency, contributing to workforce variability and limited capacity to expand services rapidly[4–6]; and

Whereas, expanding equitable access to HRA requires coordinated efforts addressing reimbursement, workforce development, referral infrastructure, and integration into HIV and other high-risk care settings; therefore be it

RESOLVED, that our American Medical Association collaborate with relevant national medical specialty societies to promote development and dissemination of evidence-based and practical guidance, referral pathways, and implementation strategies to integrate anal cancer screening and HRA access into routine care for high-risk populations (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage and promote educational resources, training opportunities, and competency guidance related to high-resolution anoscopy developed by relevant medical specialty societies and other expert organizations in order to support expansion of patient access and an appropriately trained workforce (New HOD Policy); and be it further

RESOLVED, that our American Medical Association advocate at the federal and state levels for policies that expand equitable access to high-resolution anoscopy (HRA) for high-risk populations, including ensuring adequate reimbursement, reducing geographic disparities, and supporting workforce development (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage federal agencies, including the Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS), to support funding mechanisms and demonstration programs that expand HRA capacity in HIV care settings, federally qualified health centers, and underserved communities. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-440.872 HPV Associated Cancer Prevention

1. Our American Medical Association;
a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and
b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA;
a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits;
b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups , including but not limited to low-income and pre-sexually active populations; and

c. recommends HPV vaccination for all groups for whom national medical specialty societies or the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.
[Res. 503, A-07 Appended: Res. 6, A-12 Reaffirmed: CSAPH Rep. 1, A-22 Reaffirmation: A-22 Modified: Res. 916, I-22 BOT Action Sept. 2023 Modified: CSAPH Rep. 03, I-24 Appended: BOT Rep. 24, I-25]

H-460.913 Screening for HPV-Related Anal Cancer
1. Our American Medical Association supports continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer.
2. Our AMA's advocacy efforts to implement screening for anal cancer for high-risk populations.
3. Our AMA's national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.
[Res. 512, A-04 Reaffirmed: CSAPH Rep. 1, A-14 Appended: Res. 421, A-22]

H-465.994 Improving Rural Health
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.
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 Reaffirmed: Res. 237, I-25 Reaffirmed: CMS Rep. 03, I-25]

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.
[CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24 Appended: Res. 413, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-26)

Introduced by: LGBTQ+ Section

Subject: Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)

Referred to: Reference Committee D

Whereas, HIV pre-exposure prophylaxis (PrEP) is a highly effective biomedical intervention which, when taken as prescribed, can reduce the risk of sexual HIV acquisition by about 99% and has become a cornerstone of national HIV-prevention strategies [1-2]; and

Whereas, existing AMA policy (H-20.895, H-20.894, H-165.821) already supports education about PrEP, coverage of all approved PrEP regimens, removal of insurance barriers, inclusion of PrEP as a preventive essential health benefit, and expanded access through physician-led collaborative practice models but lack policy regarding ways to improve access and uptake in target populations [3]; and

Whereas, recent federal and state budget proposals, litigation targeting the preventive-services mandate, and the patchwork nature of federal, state, and private assistance programs have introduced substantial uncertainty and instability in PrEP medication and service funding, threatening continuity of care and jeopardizing progress toward ending the HIV epidemic [4-12]; and

Whereas, although overall PrEP use has increased in the United States, national surveillance repeatedly shows that only a minority of people with PrEP indications actually receive it, with particularly low uptake among cisgender women and people living in the Southern United States [13-14]; and

Whereas, profound disparities in PrEP awareness, access, and adherence persist among populations disproportionately affected by HIV - including women (particularly Black, Latina, Indigenous, transgender, and Southern women), as well as Black, Latino, Indigenous, and rural communities - despite overall growth in PrEP use nationally [13, 15-17] ; and

Whereas, transgender women face a disproportionate burden of HIV and, despite high levels of interest in PrEP, experience multiple barriers - including discrimination, lack of gender-affirming care, and limited provider knowledge - underscoring the need for tailored, affirming PrEP delivery models [17-18]; and

Whereas, women account for a substantial proportion of new HIV diagnoses globally and in the United States, and gendered power dynamics, reproductive coercion, intimate partner violence, economic dependence, and stigma can limit women's ability to negotiate condom use or disclose PrEP use, making PrEP access and autonomy over HIV prevention a critical reproductive health and bodily autonomy issue [19-20]; and

Whereas, many clinicians report limited training, time, or comfort in discussing sexual health and PrEP with patients - especially women, transgender and gender-diverse people, and people

in rural areas - highlighting the importance of integrating PrEP education into medical school curricula, graduate medical education, and continuing medical education [1,2, 21]; and

Whereas, the NIH Office of AIDS Research and the Office of Research on Women's Health have highlighted persistent HIV disparities among women and gender-diverse people, calling for women-centered prevention and care strategies across the lifespan—including improved access to PrEP, trauma-informed services, and integration of HIV prevention with sexual and reproductive health care [22]; and

Whereas, innovative PrEP delivery models - including telePrEP, same-day or rapid-start initiation, community-based and mobile services, pharmacy-based and home-based PrEP monitoring, and integration of PrEP into primary care, sexual-health clinics, substance-use-disorder treatment programs, and services for survivors of sexual assault - have been shown to reduce barriers, improve uptake, and reach populations underserved by traditional clinic-based models [21, 23]; and

Whereas, social determinants of health such as housing instability, lack of transportation, childcare responsibilities, limited paid leave, medical mistrust, and intersectional stigma (including racism, sexism, homophobia, and transphobia) continue to impede PrEP uptake and persistence, particularly for women and marginalized communities, and require coordinated policy and systems-level responses [4-13]; and

Whereas, legal and policy threats to coverage for preventive services, including PrEP, create confusion among payers, providers, and patients, and may have a chilling effect on prescribing or seeking PrEP unless strong medical and public health voices advocate for continued, reliable access [4-12]; and

Whereas, aligning AMA policy with evolving evidence and best practices to emphasize funding stability, equity-focused implementation, innovative delivery models, and attention to social determinants of health will strengthen ongoing AMA efforts to end the HIV epidemic and advance gender and racial health equity [1-3, 22]; therefore be it

RESOLVED, that our American Medical Association supports advocacy, research funding, and targeted programmatic support to address disparities in PrEP access among populations disproportionately affected by HIV, ensuring that strategies are tailored to the unique needs of these communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to expand PrEP access to all individuals in alignment with evidence-based guidelines and shared decision making, including but not limited to innovative delivery models across various care settings and strategies to address social determinants of health that impede PrEP uptake such as housing instability, transportation barriers, and stigma. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity

Our AMA:

(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;

(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;

(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.

PrEP is an Essential Health Benefit H-165.821

1. Our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as a Preventive Essential Health Benefit under the Patient Protection and Affordable Care Act.

2. Our AMA will support and join legal efforts to overturn the judgment rendered in Braidwood v. Becerra in the U.S. District Court for the Northern District of Texas.

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our American Medical Association will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling.

HIV, Sexual Assault, and Violence H-20.900

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Improving PrEP & PEP Access H-20.894

Our American Medical Association supports efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and physicians, based on AMA's model legislation related to collaborative drug therapy management.
1. Our AMA supports a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:424
(A-26)

Introduced by: LGBTQ+ Section

Subject: Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)

Referred to: Reference Committee D

Whereas, more than 2.2–2.4 million cases of chlamydia, gonorrhea, and syphilis are reported annually in the United States, with overall sexually transmitted infection (STI) morbidity remaining substantially higher than a decade ago and congenital syphilis increasing nearly 700% over ten years [1-3]; and

Whereas, these infections disproportionately affect adolescents and young adults, men who have sex with men (MSM), transgender women, and racial and ethnic minority populations, contributing to persistent health inequities [1-3]; and

Whereas, cisgender women and people who were assigned female at birth (transgender and gender diverse individuals) bear the highest global burden of STIs [4]; and

Whereas, bacterial STIs are associated with serious complications including pelvic inflammatory disease, infertility, chronic pelvic pain, increased HIV acquisition risk, and severe adverse fetal and neonatal outcomes from congenital syphilis [1, 3-6]; and

Whereas, traditional prevention strategies (abstinence, reduction in number of sexual partners, barrier protection, and routine testing) are not sufficient alone to address the current STI burden, particularly in populations facing structural and social barriers to care [7]; and

Whereas, randomized clinical trials among MSM and transgender women with recent bacterial STIs have demonstrated that doxycycline postexposure prophylaxis (DoxyPEP), dosed as 200 mg within 72 hours after condomless sex, reduces the combined incidence of gonorrhea, chlamydia, and syphilis by approximately two-thirds compared with standard care [8-10]; and

Whereas, in 2024, the Centers for Disease Control and Prevention issued clinical guidelines recommending that MSM and transgender women with a bacterial STI diagnosed in the past 12 months be counseled about and, after shared decision-making, be offered DoxyPEP as an ongoing, patient-managed STI prevention strategy [11]; and

Whereas, while cisgender women and people who were assigned female at birth are not explicitly listed in current clinical guidelines, guidelines could specifically address strategies for clinicians to discuss DoxyPEP with cisgender women and people who were assigned female at birth within the existing list of user education and support recommendations, or produce a shared decision-making toolkit as an appendix to guidelines to minimise this gap while awaiting further efficacy data [3, 12-14]; and

Whereas, existing AMA policies strongly support HIV pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) through physician and trainee education, insurance coverage, and removal of access barriers, and support comprehensive, evidence-based sexual health education [15]; and

Whereas, AMA currently lacks explicit policy on the use, education, and coverage of DoxyPEP for bacterial STI prevention, despite emerging evidence and clinical guidance [15]; therefore be it

RESOLVED, that our AMA supports physician and trainee education on Postexposure Doxycycline (DoxyPEP) and other anti-microbial postexposure treatments (New HOD Policy); and be it further

RESOLVED, that our AMA supports prescribing and insurance coverage of Postexposure Doxycycline (DoxyPEP) for sexually transmitted infection (STI) prevention. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

PrEP is an Essential Health Benefit H-165.821

1. Our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as a Preventive Essential Health Benefit under the Patient Protection and Affordable Care Act.
2. Our AMA will support and join legal efforts to overturn the judgment rendered in Braidwood v. Becerra in the U.S. District Court for the Northern District of Texas.

Discrimination and Criminalization Based on HIV Seropositivity H-20.914

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity
Our AMA:
(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;

(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;
(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our American Medical Association will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling.

HIV, Sexual Assault, and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
1. Our American Medical Association supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction.
2. Our AMA urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that:
    a. are based on rigorous, peer reviewed science;
    b. incorporate sexual violence prevention;
    c. show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant;
    d. include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;

e. utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth;
f. appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;
g. include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program;
h. are part of an overall health education program; and
i. include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

3. Our AMA will continue to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate.
4. Our AMA will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program.
5. Our AMA opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems.
6. Our AMA endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes.
7. Our AMA supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits.
8. Our AMA extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy.
9. Our AMA supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent.
10. Our AMA encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Improving PrEP & PEP Access H-20.894

1. Our American Medical Association supports efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and physicians, based on AMA's model legislation related to collaborative drug therapy management.
2. Our AMA supports a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-26)

Introduced by: American College of Emergency Physicians

Subject: Prioritizing, Measuring, and Preventing Workplace Violence in Health Care

Referred to: Reference Committee D

Whereas, nearly 75% of all workplace assaults in the United States occur in health care and social service settings, reflecting a disproportionate burden of violence in these environments; and

Whereas, emergency departments are particularly vulnerable settings, with 91% of emergency physicians reporting that they or a colleague experienced workplace violence in the past year, 47% reporting physical assault, and 71% witnessing assaults against colleagues; and

Whereas, workplace violence threatens the physical and psychological safety of health care professionals and undermines the delivery of safe, effective patient care; and

Whereas, unsafe work environments contribute to workforce instability, with nearly one in five physicians reporting symptoms of depression and approximately 29% of health care workers intending to leave their jobs within two years; and

Whereas, current efforts to collect and report workplace violence data remain inconsistent across jurisdictions, limiting the ability to understand national trends and implement effective interventions; and

Whereas, health care workers may be dissuaded from reporting workplace violence due to concerns about institutional liability, reputational harm to health care organizations, normalization of violence (e.g., attribution to intoxication or illness), and fear of retaliation or lack of meaningful follow-up; and

Whereas, existing policy of our American Medical Association encourages the development of workplace violence prevention standards, supports research and funding to evaluate effective interventions, and promotes dissemination of best practices (H-515.957, D-515.983); and

Whereas, existing policy of our AMA encourages health care facilities to implement reporting tools, training programs, and institutional policies to reduce workplace violence (H-515.966); and

Whereas, current AMA policy addressing workplace violence is distributed across multiple policies and directives, creating fragmentation that may limit clarity, coordination, and effectiveness of advocacy efforts; therefore be it

RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition (Directive to Take Action); and be it further

RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce (Directive to Take Action); and be it further

RESOLVED, that our AMA rescind existing policies H-515.957 (Preventing Violent Acts Against Health Care Providers), D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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6. American Medical Association. Preventing Violent Acts Against Health Care Providers D-515.983.
7. American Medical Association. Violence and Abuse Prevention in the Health Care Workplace H-515.966.

RELEVANT AMA POLICY

American Medical Association. Preventing Violent Acts Against Health Care Providers H-515.957.
American Medical Association. Preventing Violent Acts Against Health Care Providers D-515.983.
American Medical Association. Violence and Abuse Prevention in the Health Care Workplace H-515.966.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-26)

Introduced by: American College of Cardiology

Subject: Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")

Referred to: Reference Committee D

Whereas, diet-related chronic diseases—including cardiovascular disease, diabetes, and obesity—remain leading causes of morbidity, mortality, and health care expenditures in the United States; and

Whereas, food insecurity and poor diet quality disproportionately affect individuals with lower socioeconomic status and contribute to adverse cardiovascular outcomes and widening disparities; and

Whereas, "Food is Medicine" interventions—including medically tailored meals, medically tailored groceries, and produce prescription programs—have demonstrated improvements in health outcomes, reductions in hospitalizations, and lower health care costs; and

Whereas, the bipartisan Medically Tailored Home-Delivered Meals Demonstration Pilot Act (H.R. 5439 / S. 2834) would establish a Medicare pilot program to deliver medically tailored meals to patients with diet-related chronic disease and evaluate impacts on outcomes and costs; and

Whereas, bipartisan Congressional efforts, including a Fiscal Year 2027 Labor–HHS appropriations letter led by Jim McGovern (D-MA-02), Vern Buchanan (R-FL-16), Chellie Pingree (D-ME-01), and Emilia Sykes (D-OH-13), call for strengthening and expanding Food is Medicine initiatives and integrating nutrition into the U.S. health care system; and

Whereas, the American Medical Association has affirmed that "food is medicine" and is committed to advancing nutrition education, research, and policy efforts to improve chronic disease outcomes; and

Whereas, current clinical practice guidelines, including Section 4.1.2.1 of the recently published 2026 American College of Cardiology/American Heart Association lipid management guidelines, support plant-based dietary patterns across the lifespan for primary and secondary prevention of atherosclerotic cardiovascular disease; and

Whereas, despite strong evidence and guideline support, access to health-promoting foods remains limited for many patients due to cost, availability, and structural barriers; therefore be it

RESOLVED, that our American Medical Association recognizes Food is Medicine interventions—including medically tailored meals—as evidence-based strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity (New HOD Policy); and be it further

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for Food is Medicine initiatives through the yearly Labor–HHS appropriations process (New HOD Policy); and be it further

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance Food is Medicine interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/20/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-26)

Introduced by: Medical Student Section

Subject: Infant Feeding Options for HIV-Seropositive Individuals

Referred to: Reference Committee D

Whereas, human milk's composition of nutrients, along with its antimicrobial, anti-inflammatory, and immunoregulatory agents makes it uniquely ideal for human infants and has been associated with decreased incidence of lower respiratory infections, otitis media, SIDs, and overall neonatal and infant mortality [1-5]; and

Whereas, human milk also has proven decreased incidence of other later-onset diseases including but not limited to, obesity, Type 1 and Type 2 diabetes, and inflammatory bowel disease[6–9]; and

Whereas, breastfeeding has many health benefits for the lactating person, such as decreased incidence of several types of cancer, type 2 diabetes, and hypertension[10–12]; and

Whereas, despite its extensive proven benefits, there are extensive disparities in breastfeeding rates, particularly as the rates in non-Hispanic White and Hispanic populations are significantly higher than in non-Hispanic Black populations[13]; and

Whereas, evidence, including the multi-country PROMISE trial, places the transmission rate of HIV from parent to breastfeeding infants as less than 5%, and less than 1% for parents that have a suppressed viral load[16]; and

Whereas, due to the extensive benefits of breastfeeding for infants and the lactating parent, the newer evidence of low rates of transmission by parents adequately virally suppressed by ART has prompted greater discussion of infant feeding options; and

Whereas, the National Institutes of Health (NIH) recommends clinicians support the choice of HIV seropositive individuals to breastfeed if they are virally suppressed, or to formula/replacement feed[17]; and

Whereas, the American Academy of Pediatrics (AAP) supports breastfeeding among HIV seropositive individuals who desire to do so if criteria are met, including early ART initiation, sustained viral suppression, adherence to ART and infant prophylaxis, and reliable ART access[18]; and

Whereas, our AMA has adopted multiple policies supporting breastfeeding, including H-245.982 ("AMA Support for Breastfeeding") and D-310.950 ("Protecting Trainee's Breastfeeding Rights"); and

Whereas, AMA Policy H-20.916 currently advises clinicians to unequivocally counsel HIV seropositive patients against breastfeeding where alternative nutrition is available, which is inconsistent with evidence and recommendations; therefore be it

RESOLVED, that the American Medical Association amend Policy H-20.916, "Breastfeeding and HIV Seropositive People," by addition and deletion as follows:

Breastfeeding and HIV Seropositive People, H-20.916

Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. ~~be counseled not to breastfeed and not to donate breast milk.~~ HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-20.916 Breastfeeding and HIV Seropositive Individuals
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. [CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 8, A-23]

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission
In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:
(1) Given the prevalence and distribution of HIV infection among individuals in the United States, the potential for effective early treatment of HIV infection, and the significant reduction in perinatal HIV transmission with treatment of pregnant people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all individuals. The ideal would be for all people to know their HIV status before considering pregnancy.
(2) Universal HIV testing of all pregnant people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
(3) The final decision about accepting HIV testing is the responsibility of the patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for patients and their infant.
(4) To assure that the intended results are being achieved, the proportion of pregnant people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.
(5) Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.
(6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.
(7) Appropriate medical treatment for HIV-infected pregnant people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the patient presents for prenatal or intrapartum care.
(8) To facilitate optimal medical care for pregnant people and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a pregnant person or their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the pregnant patient and their infant, consistent with applicable state law.
(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for patients presenting in labor and those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up

studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.
(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected pregnant people, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-245.982 AMA Support for Breastfeeding
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
(2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
(3) Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
(4) Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
(5) Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05Res. 325, A-05Reaffirmation A-07Reaffirmation A-12Modified in lieu of Res. 409, A-12 and Res. 410, A-12Appended: Res. 410, A-16Appended: Res. 906, I-17Reaffirmation: I-18]

D-310.950 Protecting Trainees' Breastfeeding Rights
(1) Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to

include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk.
(2)Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews. [Res. 302, I-16Modified: Speakers Rep. 02, I-24].

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-26)

Introduced by: Medical Student Section

Subject: Protecting Environmental Health Before, During, and After War

Referred to: Reference Committee D

Whereas, according to the World Health Organization (WHO), healthier environments could prevent almost one-quarter of the global burden of disease, as clean air, a stable climate, safe water, sanitation, and hygiene (WASH), safe use of chemicals, protection from radiation, healthy workplaces, sustainable agriculture, health-supportive cities, and preserved natural ecosystems are all prerequisites for good health;[1] and

Whereas, according to the UN Environment Programme (UNEP), heavy bombardment of populated areas contaminates soil, air, and groundwater from the munitions and the release of hazardous materials such as asbestos, industrial chemicals, and fuel, creating long-term environmental and health hazards;[2] and

Whereas, explosives use destroys water supplies and sanitation facilities, leading to pollution from sewage; in rural areas, bombing decreases soil quality and agricultural productivity by disrupting topography and altering drainage patterns; and unexploded remnants of war left behind continue to injure and kill civilians for years;[3] and

Whereas, the sinking of military vehicles during conflicts has caused long-term oil spills, including wrecks off of the Iraqi coast that release hydrocarbons into the Persian Gulf linked to cancer, anemia, organ damage, and neurological harm, contaminating Kuwaiti desalination plants that supply the majority of regional drinking water;[4] and

Whereas, the U.S. Department of Defense is the world's largest institutional consumer of oil and among the world's top greenhouse gas emitters, adding significantly to climate change;[3] and

Whereas, between 1961 and 1971, more than 91 million liters of Agent Orange, containing persistent environmental pollutants (POPs) that accumulate in food sources, were applied across 3.1 million hectares of Vietnam, exposing over 4 million people to toxic dioxins, leading to cancers, congenital disabilities, and intergenerational harm;[5,6] and

Whereas, more than 600 U.S. military sites have been designated as Superfund sites, reflecting widespread contamination of air, soil, and water by hazardous substances associated with defense activities;[7] and

Whereas, proximity to toxic waste and Superfund sites has been linked to increased risks of cancer, congenital anomalies, and other adverse health outcomes, with disproportionate impacts on low-income and minority communities;[8] and

Whereas, supporting evidence from the U.S. Environmental Protection Agency (EPA) Discharge Monitoring Reports documents releases of arsenic, cyanide, and lead by the Atlantic Fleet Weapons Training Facility on Vieques Island, Puerto Rico, into surrounding waters of the live

impact area, demonstrating that environmental pollution can lead to adverse neonatal outcomes;[9] and

Whereas, a 2023 Department of Defense brief acknowledged over 245 military bases where polyfluoroalkyl substances (PFAS), known endocrine disruptors, may have contaminated groundwater aquifers that serve as sources of drinking water;[10,11] and

Whereas, the Vanadium Corporation's recruitment of Navajo lands to mine uranium for atomic bombs, without informing local community members of the purpose or health risks, led to the Church Rock incident, the largest accidental release of radioactive material in U.S. history into the Rio Puerco, as well as elevated radiation-induced disease in Navajo communities including renal failure, hypertension, cancer, reduced fertility, and more;[12,13] and

Whereas, during and after conflicts, environmental governance, waste management, and ecosystem services often collapse, compounding exposure risks and intensifying future conflict risks;[14] and

Whereas, the American College of Occupation and Environmental Medicine has underscored that capacity building in environmental medicine, including training in taking exposure histories and reporting sentinel events (such as outbreaks of waterborne illness and clusters of toxic exposure), is necessary for clinicians seeing displaced and/or conflict-impacted populations;[15] and

Whereas, military greenhouse gas emissions were excluded from the 1997 Kyoto Protocol, and military emissions reporting under the 2015 Paris Agreement was made voluntary, resulting in systematic underestimation of warfare's climate toll;[16] and

Whereas, the UN General Assembly states that areas of environmental importance should be designated as protected zones in armed conflict;[17] and

Whereas, international law, including the Rome Statute of the ICC and the Geneva Conventions, prohibits methods of warfare that cause widespread, long-term, and severe environmental damage, recognizing such acts as war crimes;[18] therefore be it

RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities that the U.S. is involved in (New HOD Policy); and be it further

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to U.S. and U.S.-supported military activities, including armed conflict and weapons production, that lead to adverse health outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA supports the development, availability, and use of continued medical education for clinicians to take exposure histories, counsel patients, and report sentinel events in displaced and conflict-affected populations impacted by environmental health harms. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

D-135.966 Climate Change as a Public Health Crisis

Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals.

Our AMA will protect patients by advocating for policies that:

Limit global warming to no more than 1.5 degrees Celsius.

Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.

Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and making a commitment to lower its own greenhouse gas emissions.

Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.

Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component

of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes. [Res. 420, A-22Appended: CSAPH Rep. 02, I-22Appended: BOT Rep. 11, I-24]

H-135.938 Global Climate Change and Human Health
Our American Medical Association supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

Recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public.
Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [CSAPH Rep. 3, I-08Reaffirmation A-14Reaffirmed: CSAPH Rep. 04, A-19Reaffirmation: I-19Modified: Res. 424, A-22Modified: CSAPH Rep. 2, I-22]

H-135.991 Clean Air / Environmental Health
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. [BOT Rep. R, A-82Reaffirmed: CLRPD Rep. A, I-92Amended: CSA Rep. 8, A-03Reaffirmation I-06Reaffirmed in lieu of Res. 509, A-09Reaffirmation I-09Reaffirmation A-14Modified: CSAPH Rep. 01, A-24]

D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War
1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.
2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war. [Res. 436, A-05Appended: Res. 524, A-15Reaffirmed: Res. 007, A-24]

D-135.962 Hazardous Pollutants and Heavy Metals
Our American Medical Association urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air.
Our AMA supports efforts to:
monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits;
monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites; and
educate individuals on the chronic effects of those exposures. [Res. 409, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-26)

Introduced by: Medical Student Section

Subject: Adolescent Dating Violence Comprehensive Screening Tool Development

Referred to: Reference Committee D

Whereas, adolescent dating violence (ADV), also referred to as adolescent intimate partner violence, is a prevalent public health problem in the United States, with national surveys estimating that over 1 in 8 high school students reported experiencing physical violence, sexual violence, or both by someone they were dating in the past year, with trend analyses showing an overall increase in sexual dating violence between 2019 and 2021[1-3]; and

Whereas, psychological and emotional abuse is even more common, with over 60% of adolescent daters reporting such experiences in national surveys, and up to 75% reporting technology-assisted or cyber abuse from people they are dating[4,5]; and

Whereas, adverse childhood experiences (ACEs) increase vulnerability to, but are distinct from, adolescent dating violence, as ACEs typically precede ADV while ADV constitutes a separate form of interpersonal violence with unique risk factors and consequences[6-8]; and

Whereas, those who experience the intersectionality of identities such as racial/ethnic backgrounds, sexual orientation and gender identity, and underserved community status are disproportionately affected by adolescent dating violence; and

Whereas adolescents who experience dating violence are at significantly increased risk for depression, anxiety, suicidality, substance use, high risk sexual behaviors, future intimate partner violence, and significantly higher odds of emergency department utilization, independent of other risk factors[15-18]; and

Whereas, failure to routinely screen adolescents for dating violence in clinical and school settings leads to missed opportunities for early intervention, support, and referral to evidence-based services, perpetuating a cycle of recurrent victimization, perpetration, and chronic mental health and substance use disorders into adulthood[15-18]; and

Whereas, despite these risks, there is a lack of comprehensive, validated, and routinely used screening tools for adolescent dating violence in the United States as adult intimate partner violence screening instruments (HARK, HITS, E-HITS, PVS, WAST) have not been validated for adolescents and are rarely used in pediatric clinical practice—a gap recognized by the U.S. Preventive Services Task Force, despite encouragement from the American Academy of Pediatrics[19-21]; and

Whereas, while the MARSHA-C (Measure of Adolescent Relationship Harassment and Abuse – Compact) was developed with input from diverse youth and shows promising validity, its limited sample size, single online validation, lack of replication in clinical settings, and absence of cross-cultural or long-term outcome data mean it is not yet established for routine clinical use[29-32]; and

Whereas, a recent systematic review found a large degree of mistrust of available dating violence resources among African American and Latino youth, largely due to a lack of culturally sensitive interventions within these resources[32]; and

Whereas, current adult and adolescent dating violence prevention tools have been shown to reduce physical violence, but there has been a lack of statistically significant progress in reducing sexual violence, suggesting that new and more inclusive screening tools and interventions are needed[33]; therefore be it

RESOLVED, that our American Medical Association ask relevant stakeholders, including federal agencies, academic institutions, and professional societies, to support the development of validated, culturally sensitive, LGBTQ+ inclusive adolescent-specific screening tools for adolescent intimate partner violence that can be easily implemented in the clinic setting. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 04/20/2026

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:
Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care.
Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before they leave the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course.
After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.
Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid.
Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence.
Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV.
(Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves.
Give due validation to the experience of IPV and of observed symptomatology as possible sequelae.
Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made.
Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
Within the larger community, our AMA:
Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, our AMA believes the laws must incorporate provisions that:
do not require the inclusion of survivors' identities;
allow competent adult survivors to opt out of the reporting system if identifiers are required;
provide that reports be made to public health agencies for surveillance purposes only;
contain a sunset mechanism; and
evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough

to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. [CSA Rep. 7, I-00Reaffirmed: CSAPH Rep. 2, I-09Modified: CSAPH Rep. 01, A-19Modified: Speakers Rep. 02, I-24]

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. [Res. 303, I-96Reaffirmed: CME Rep. 2, A-06Reaffirmed: CME Rep. 01, A-16]

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will:
(1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. [Res. 903, I-17Modified: CSAPH Rep. 01, I-18]

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
Our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
Our AMA supports:
evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs).
evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs.
efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting.
funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.
increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant. increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
Our AMA will collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs)

categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them.

Our AMA will work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions.

Our AMA will support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child. [Res. 504, A-19Appended: CSAPH Rep. 3, A-21Appended: Res. 914, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-26)

Introduced by: Medical Student Section, Oregon, Washington

Subject: Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires

Referred to: Reference Committee D

Whereas, wildfires in the United States are increasing in frequency and intensity, driven in part by climate change, with the annual acreage burned doubling in recent decades[1]; and

Whereas, urban and suburban wildfires increasingly burn homes, vehicles, electronics, and industrial facilities, producing hazardous air, soil, and water contamination distinct from forest-only fires[2]; and

Whereas, toxic substances released by burning urban infrastructure include heavy metals such as lead, arsenic, mercury, and cadmium, as well as polycyclic aromatic hydrocarbons (PAHs), dioxins, and volatile organic compounds (VOCs)[3]; and

Whereas, wildfire smoke can travel hundreds of miles, exposing populations far beyond the burn zone to toxic pollutants, with documented effects on air quality across entire regions[4]; and

Whereas, wildfire smoke exposure is associated with increased hospital admissions for respiratory disease, cardiovascular events, and premature mortality, as well as with increased risk of some types of cancer[5-7]; and

Whereas, wildfire byproduct exposure is estimated to cause tens of thousands of hospitalizations and premature deaths each year, resulting in billions of dollars in health care costs and lost productivity nationwide[8-11]; and

Whereas, fire suppressants used to combat wildfires often themselves contain heavy metals contributing to environmental contamination[12]; and

Whereas, toxic heavy metals such as lead and cadmium persist in the environment long after fires are extinguished, contaminating soil, groundwater, and household dust[13,14]; and

Whereas, the CDC lowered the blood lead reference value for children in 2021, monitoring for mild or moderate environmental exposures and chronic exposure is associated with irreversible neurocognitive deficits in children, as well as hypertension, renal dysfunction, and adverse pregnancy outcomes[15-17]; and

Whereas, first responders, cleanup workers, utility crews, and residents can become exposed to harmful smoke during and after fires, and this exposure can be detected and quantified with post-incident urine testing for smoke byproducts (PAHs)[18]; and

Whereas some state public health agencies, in coordination with national agencies, have tested residents for heavy metal toxicity following wildfire, yet such testing is not standardized nor implemented after all wildfires[19,20]; therefore be it

RESOLVED, that our American Medical Association supports the development, dissemination, and implementation of voluntary post-wildfire toxicant exposure screening protocols, covering heavy metals, polycyclic aromatic hydrocarbons (PAHs), and other dangerous air pollutants and toxic substances, for wildfire-impacted individuals and communities, in coordination with appropriate public health and environmental agencies, universities, public health schools and societies (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts, in partnership with public health and environmental agencies, to ensure access to environmental monitoring, mobile health services, medical follow-up, and treatment for individuals exposed to toxic substances during or after wildfire events, with particular attention to frontline, vulnerable and disproportionately impacted communities. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health
Our American Medical Association supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

Recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public.
Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

D-135.962 Hazardous Pollutants and Heavy Metals
Our AMA (1) urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air. (2a) monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits; (2b) monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites; and (2c) educate individuals on the chronic effects of those exposures. [Res. 409, A-24]

H-60.924 Reducing Lead Poisoning
Our American Medical Association:
supports regulations and policies designed to protect young children from exposure to lead;
urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure;
encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories;

promotes community awareness of the hazard of lead-based paints; and
urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant people and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals:
adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant people and children from lead toxicity and neurodevelopmental impairment;
identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed;
continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services;
eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and
establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant people and children, defined as blood lead levels above 1 µg/dL (10 ppb).
Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
Our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water.
Our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies.
Our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks.
Our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure.
Our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas.
Our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies. [CCB/CLRPD Rep. 3, A-14Appended: Res. 926, I-16Appended: Res. 412, A-17Modified: Res. 432, A-24Modified: Speakers Rep. 02, I-24]

D-135.992 Mercury Pollution
Our American Medical Association recognizes that the trading of air pollutants is potentially harmful for vulnerable populations.
Our AMA encourages state governments to be proactive in protecting citizens from harmful mercury emissions.
Our AMA encourages reduction in mercury use in manufacturing wherever possible, and recognize that more must be done using available and emerging technology to reduce mercury emissions.
Our AMA recommends increased vigilance, monitoring and tracking of mercury use and emissions in chlor-alkali facilities that use mercury in manufacturing processes.
Our AMA encourages the US government to assume a leadership role in reducing the global mercury burden and work toward promoting binding, health-protective international standards.

Our AMA supports the Environmental Protection Agency's national mercury emissions standards for cement kilns at limits based on the latest pollution control technology.
Our AMA supports modern and strict source monitoring of mercury emissions from cement plants. [CSAPH Rep. 1, I-06Appended: Res. 501, A-11Reaffirmation A-14Modified: CSAPH Rep. 01, A-24]

H-135.999 Federal Programs
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants. [BOT Rep. M, A-63Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmation I-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate
Our American Medical Associaiton supports initiatives to promote environmental sustainability and other efforts to halt global climate change.
Our AMA will incorporate principles of environmental sustainability within its business operations.
Our AMA supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Our AMA supports a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change.
Our AMA encourages health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities.
Our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity.
Our AMA supports the Joint Commission’s Sustainable Healthcare Certification, which supports health systems in pursuing decarbonization by establishing greenhouse gas (GHG) baseline emissions as well as measuring and documenting GHG reductions.
Our AMA supports the development of strategies and technologies to strengthen supply chain networks, including economic incentives for building climate and disaster resiliency and redundancy into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. [Res. 924, I-16Reaffirmation: I-19Modified: Res. 415, A-24Appended: Res. 907, I-24Appended: Res. 914, I-24]

H-135.973 Stewardship of the Environment
Our AMA encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients.
Our AMA encourages the medical community to cooperate in reducing or recycling waste.
Our AMA encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner.
Our AMA supports enhancing the role of physicians and other scientists in environmental education.
Our AMA endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention.
Our AMA encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes.
Our AMA encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation.
Our AMA encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment.
Our AMA encourages educational programs for worldwide family planning and control of population growth.
Our AMA encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy.
Our AMA encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.

Our AMA encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment.
Our AMA encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives.
Our AMA encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues.
Our AMA will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS).
Our AMA encourages expanded funding for environmental research by the federal government.
Our AMA encourages family planning through national and international support.
Our AMA recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste.
Our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons.
Our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions.
Our AMA opposes corporate “greenwashing,” or the act of making misleading statements about the environmental benefits of products and/or services.
Our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development.
Our AMA supports the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care.
Our AMA supports financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations.
Our AMA supports the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change.
Our AMA supports further research on the health- and climate-related effects of consuming plant-based and lab-grown meat. [CSA Rep. G, I-89Amended: CLRPD Rep. D, I-92Amended: CSA Rep. 8, A-03Reaffirmed in lieu of Res. 417, A-04Reaffirmed in lieu of Res. 402, A-10Reaffirmation I-16Modified: Res. 414, A-24Appended: Res. 420, A-25]

D-440.912 AMA Public Health Strategy
Our American Medical Association will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.
Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the en of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023.
Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023.
Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023.
Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country. [BOT Rep. 17, A-23Modified: BOT Rep. 05, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-26)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Supporting Transportation Infrastructure Reform for Public Health

Referred to: Reference Committee D

Whereas, the American Medical Association (AMA) recognizes robust transportation infrastructure as a fundamental social determinant of health that directly impacts patient access to medical facilities, pharmacies, and essential community services [1–4]; and

Whereas, in 2017, 5.8 million individuals in the United States delayed medical care due to a lack of transportation, with such barriers being responsible for 25% of all missed clinic appointments, representing a significant risk factor for long-term mortality among patients with chronic conditions [5–7]; and

Whereas, segments of transportation often have poor connectivity in the United States due to lack of suitable pedestrian infrastructure, with sidewalks having 45% less spatial access than roads, thus disproportionately disadvantaging individuals reliant on them, such as elderly, children, and individuals with disabilities [8]; and

Whereas, since the 1980s, U.S. transportation infrastructure has prioritized automobile access, allocating approximately 80% of federal transportation funding to highways and less than 20% to public transit infrastructure, while active transport networks face an estimated $7 billion funding shortfall, resulting in consistently underfunded, unaffordable, and unreliable accessible transportation options [3,9]; and

Whereas, current federal transportation formulas and design standards (e.g. reliance on vehicle miles traveled and road throughput), prioritize automobile speed over safety, incentivizing road designs that endanger pedestrians, cyclists, and transit users [6]; and

Whereas, vulnerable road users (e.g. cyclists, pedestrians) comprise approximately 20% of all traffic fatalities with pedestrian deaths reaching a 40-year high, yet many states have raised the allowable numbers of deaths and serious injuries among these users, with a disproportionate burden in marginalized communities [3,6]; and

Whereas, “Complete Streets” is a transportation policy approach that requires streets to be designed for safe access for pedestrians, bicyclists, public transportation, as well as motorists for users of all ages and abilities, incorporating robust pedestrian and cycling infrastructure, traffic calming measures, and public transport accommodations [10]; and

Whereas, access to sidewalks, bike lanes, and other active mobility infrastructure has been shown to significantly improve physical activity levels and health outcomes, with systematic reviews highlighting that walkability interventions reduce chronic disease burden and enhance equity in urban environments, as well as reduce pedestrian and biker fatalities [11-14]; and

Whereas the Federal Highway Administration released a report in March 2022 setting forth an initiative to adopt the Complete Streets design model in its approach to funding and designing most federally funded roads [15]; and

Whereas, the Complete Streets Act of 2025 has been introduced to Congress and the House of Representatives, requiring states to establish Complete Street programs and dedicating 5% of federal highway funding to providing technical assistance and incentives for their development, further promoting safer streets for all users [16,17]; therefore be it

RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure; 2.) ensure safe and accessible travel for pedestrians, bicyclists, public transit users, and motorists of all ages and abilities; and 3.) place a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color (New HOD Policy); and be it further

RESOLVED, that our AMA support reform of federal transportation funding formulas, to explicitly prioritize pedestrian safety metrics, transit accessibility, and health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. [Presidential Address, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: BOT Rep. 8, I-06Reaffirmed: CSAPH Rep. 01, A-16Modified: Res. 923, I-19]

H-135.939 Green Initiatives and the Health Care Community
1. Our AMA supports responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction.
2. Our AMA supports the use of ecologically sustainable products, foods, and materials when possible.
3. Our AMA supports the development of products that are non-toxic, sustainable, and ecologically sound.
4. Our AMA supports building practices that help reduce resource utilization and contribute to a healthy environment.
5. Our AMA supports the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation.
6. Our AMA supports community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
7. Our AMA encourages pilot studies on the feasibility of urban ambulance fleets being replaced with renewably-powered vehicles when current petroleum-powered EMS ambulances become retired from service.

[CSAPH Rep. 1, I-08Reaffirmation A-09Reaffirmed in lieu of Res. 402, A-10Reaffirmed in lieu of: Res. 504, A-16Modified: Res. 516, A-18Modified: Res. 923, I-19Appended: Res. 406, A-25]

H-470.991 Promotion of Exercise
1. Our American Medical Association:
    a. supports the promotion of exercise, particularly exercise of significant cardiovascular benefit.
    b. encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

[Res. 83, parts 1 and 2, I-77Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CSAPH Rep. 1, A-10Appended: Res. 604, A-11Reaffirmed: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-26)

Introduced by: Medical Student Section, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Addiction Psychiatry, American Academy of Psychiatry and the Law

Subject: Addressing Public Health Risks of Online Sports Betting

Referred to: Reference Committee D

Whereas, since the 2018 Murphy v National Collegiate Athletic Association ruling enabled state authorization of legalized mobile sports betting,33 states and the District of Columbia have enacted laws with others actively considering legislation;[1-4] and

Whereas, professional sports leagues and broadcasters such as the NFL have fueled growth of this industry through heavy advertising, ultimately contributing to a 750% increase in industry advertising expenditures between 2019 and 2021;[5,6] and

Whereas, consumer engagement continues to rise, with an estimated 68 million Americans wagering $23.1 billion on the 2024 Super Bowl alone, a 41% increase from the prior year;[7] and

Whereas, evidence indicates DFS participation can act as a gateway to sports betting and impulsive gambling, especially among adolescents and young adults, with recent studies documenting mental health problems and addictive behaviors among DFS players resembling those observed in sports bettors;[8,9] and

Whereas, young adults are the fastest growing group of sports bettors, with 58% of college students reporting sports betting in the past year, and studies show that early exposure increases the likelihood of developing gambling disorder which is associated with financial hardship, relationship strain, depression, suicidality, and substance use;[10-15] and

Whereas, national prevalence surveys of gambling disorder largely predate the 2018 Murphy v NCAA ruling, leaving a critical data gap in understanding the scope of gambling-related harm in the online era, especially among adolescents and young adults;[16] and

Whereas, evidence suggests that online sports bettors have double the rates of gambling disorder as compared to those who gamble in other forms, but the lack of data collection since the 2018 ruling obscures the true characterization of the effect of online betting;[17] and

Whereas, Daily Fantasy Sports (DFS) platforms operate in a legal gray area under the 2006 Unlawful Internet Gambling Enforcement Act, which classifies DFS as a game of skill rather than gambling; however, regulators have increasingly scrutinized DFS contests for their resemblance to sports wagering, with one sportsbook fined millions of dollars in 2025;[18-21] and

Whereas, state regulatory frameworks for online sports betting differ substantially, with wide inconsistencies in consumer protections, allocation of funds for responsible gaming initiatives, and the types of contests permitted for wagering;[22-24] and

Whereas, many state regulatory frameworks fail to require online sportsbooks to meet the Internet Responsible Gaming Standards (IRGS) and the consumer protection guidelines set by the National Council on Problem Gambling (NCPG), leaving major gaps in protections for individuals at risk of gambling disorder;[17, 22, 25, 26,] and

Whereas, the NCPG has developed a comprehensive package of responsible online gaming standards, grounded in evidence and expert consensus, that includes self-limiting tools, access to betting history, and readily available treatment resources, representing a strong framework for uniform consumer protection and harm reduction;[26] and

Whereas, voluntary self-exclusion has been shown to be an effective tool to curb gambling disorder, however current policies are not currently effective due to lack of advertisement, promotion, monitoring, staff training, and active engagement by operators;[27] and

Whereas, gambling is increasingly recognized as a public health concern, with recent federal initiatives such as the GRIT Act (2023) and SAFE Bet Act (reintroduced 2025) underscoring bipartisan recognition of gambling disorder as a national issue requiring updated epidemiological studies and a stronger understanding of consumer protections;[28-31] therefore be it

RESOLVED, that our American Medical Association support efforts to establish federal and state consumer protections for online gambling, including sports betting and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors (New HOD Policy); and be it further

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

H-440.922 Gambling Disorder

The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention, and treatment of gambling disorder; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a gambling disorder and help is available through your local gambling hotline. [Res. 430, A-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

H-275.939 Internet Gambling

Our AMA informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children. [Res. 217, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-26)

Introduced by: Texas Medical Association

Subject: Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment

Referred to: Reference Committee D

Whereas, fragility fractures—defined as fractures resulting from low-energy mechanisms such as a fall from standing height—represent a major and growing public health crisis, leading to significant morbidity, mortality, and health care costs; and

Whereas, fewer than 25% of patients who experience a fragility fracture currently receive appropriate osteoporosis evaluation or pharmacologic treatment within one year of their fracture; and

Whereas, timely screening with dual-energy X-ray absorptiometry and fracture-risk assessment lead to reduced incidence of subsequent fractures; and

Whereas, coordinated fracture liaison services and evidence-based osteoporosis care models have demonstrated substantial reductions in secondary fractures and the resultant long-term health care expenditures; and

Whereas, the growing population of aging Americans at risk for osteoporosis and fragility fractures places an increasing burden on the state's health care system, workforce, and economic resources; therefore be it

RESOLVED, that our American Medical Association recognize fragility fractures and untreated osteoporosis as a significant and urgent public health issue in the United States (New HOD Policy); and be it further

RESOLVED, that our AMA support expanded and evidence-based osteoporosis screening efforts, including improved access to dual-energy X-ray absorptiometry scanning and Fracture Risk Assessment Tool evaluations for at-risk populations (New HOD Policy); and be it further

RESOLVED, that our AMA encourage health systems, hospitals, and physician groups to develop and implement coordinated fracture liaison services and secondary fracture prevention programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation for improved insurance coverage and payment policies for osteoporosis screening, diagnosis, pharmacologic treatment, and follow-up care (Directive to Take Action); and be it further

RESOLVED, that our AMA support nationwide public and physician education initiatives aimed at increasing awareness of osteoporosis risk factors, prevention, and the importance of post-fracture evaluation. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

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RELEVANT AMA POLICY

H-425.981 Reimbursement of Screening Bone Densitometry

Our AMA: (1) advocates for the use of bone densitometry as an important tool in assessing fracture risk and in the diagnosis of osteoporosis; (2) advocates that a clinical evaluation accompany any bone mass measurement for the evaluation of fracture risk and osteoporosis; (3) advocates for the continued participation of the patient's physician in the diagnosis, treatment, and prevention of osteoporosis; (4) encourages private third party payers to provide coverage for bone mass measurement technology and services for those individuals at high risk of osteoporosis; and (5) will lobby Congress to add men undergoing testosterone-suppressing treatment for prostate cancer and men who are at high risk for any other reason to the list of beneficiaries receiving Medicare coverage of bone density testing to screen for osteoporosis.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Vaccinations in Physician Offices

Referred to: Reference Committee D

Whereas, vaccination rates improve with physician recommendation; and

Whereas, Medicare Part B only covers influenza, pneumonia, hepatitis B, COVID, and occasionally TDAP vaccinations; and

Whereas, Medicare Part D covers all Advisory Committee on Immunization Practices (ACIP) recommended vaccines; therefore be it

RESOLVED, that our American Medical Association advocate for all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines to be covered by Medicare Part B. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

RELEVANT AMA POLICY

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related
    a. Develop a data-driven rationale for improved vaccine administration fees.
    b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
    c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
    d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

a. Increase federal resources for adult immunization to:
    i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations.
    ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered.

iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs.

b. Optimize use of existing federal resources by, for example:
   i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding.
   ii. Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example:
   i. Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B.
   ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient.
   iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

a. State Medicaid programs should increase state resources for funding vaccines by, for example:
   i. Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees.
   ii. Establishing and requiring payment of a minimum reimbursement rate for administration fees.
   iii. Increasing state contributions to vaccination costs.
   iv. Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by:
   i. Providing model vaccine coverage contracts for purchasers of health insurance.
   ii. Creating simplified rules for eligibility verification, billing, and reimbursement.
   iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers.
   iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, and national medical specialty society recommended vaccines.
      a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
      b. Improve accountability by adopting performance measurements.
      c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as of May 1, 2025, and national medical specialty society recommended vaccines as <b>partb> of the health plan.
      d. Provide incentives to encourage providers to begin immunizing by, for example:
         i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations.
         ii. Simplifying payment to and encouraging immunization by nontraditional providers.
         iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus:

i. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines.
ii. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets.
iii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP recommend adult vaccines as of May 1, 2025, and national medical specialty society recommended adult vaccines.

iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmed: I-10; Reaffirmed: I-12; Reaffirmed: I-14; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: A-22; Modified: BOT Rep. 24, I-25

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Citation: BOT Action in response to referred for decision: Res. 524, A-06; Reaffirmed: A-07; Appended: Res. 531, A-07; Reaffirmed: A-09; Reaffirmed: Res. 501, A-09; Reaffirmed: I-10; Reaffirmed: A-11; Reaffirmed in lieu of: Res 422, A-11; BOT action in response to referred for decision: Res. 422, A-11; Reaffirmed: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed> CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21; Reaffirmed: A-22; Modified: BOT Rep. 24, I-25

Reference Committee E

Report(s) of the Council on Science and Public Health

07 Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
08 Increased Transparency Among Psychotropic Drug Administration in Prisons
09 In Support of a National Drug Checking Registry

Resolutions

501 Preregistration in Medical Research
502 Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
503 Expansion of Psychedelic Assisted Therapy (PAT)
504 Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence
505 Avoiding misuse of artificial intelligence (AI) in clinical practice
506 Access To Gender Affirming Healthcare Including Clinical Trials
507 Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
508 Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
509 Preserving Gender-Affirming Surgical Care Access
510 Exosome and Peptide Use in Healthcare
511 Preserving Specialty Access to Anti-Cancer Agents
512 Medical Cannabis Use in Older Adults
513 Access, Affordability, and Safety of GLP-1 Receptor Agonists
514 Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy
515 Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making

EXECUTIVE SUMMARY

BACKGROUND. Policy D-480.951 "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," asked that our American Medical Association (AMA) collaborate with interested parties, including physicians, academic institutions, and industry leaders, to create a report with recommendations for how artificial intelligence (AI) tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated.

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the terms "artificial intelligence", "augmented intelligence", "level of evidence", and "grading of evidence". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in AI, large language models, and medical information. Additional collaboration with the AMA Center on AI and Digital Health and other key parties was utilized to incorporate broad information.

DISCUSSION. Transparency in AI refers to making the design, data sources, training process, and decision-making logic of AI systems understandable to key parties, encompassing both process-level elements and outcome-level explanations. Although explainability is essential, particularly in clinical contexts, meaningful explanation is challenging due to differences between algorithmic computation and human reasoning and must be balanced with safety, efficacy, and contextual expertise. Transparency can be supported through interpretable modeling techniques, documentation, user-centered explanation tools, and third-party evaluation frameworks, yet global standards remain fragmented across domains. Persistent challenges include the inherent opacity of complex deep-learning models, confabulations in generative systems, data biases, lack of consensus on explanation methods, proprietary limitations, and the risk that oversimplified explanations may inflate user trust without improving comprehension. These limitations complicate clinical applications: while AI could help keep evidence-based clinical guidelines current, its lack of transparency undermines reliability; similarly, integrating AI into medical education alongside established evidence-based medicine frameworks is difficult without clear mechanisms for interpretability and explanation.

CONCLUSION. AI-enabled decision support systems are reshaping how information is synthesized and applied across sectors, offering rapid analysis and evidence-informed recommendations that enhance, but do not replace, human expertise. In medicine, these tools may improve efficiency, workflow, and detection of high-risk conditions, yet their effect on patient outcomes remains undetermined due to limited long-term validation and ongoing concerns about transparency, bias, and explainability. Integrating principles of evidence-based medicine into AI design could strengthen trust and alignment with clinical standards, but major challenges persist, including opaque model reasoning, uneven transparency requirements, and risks of confabulation in generative systems. As clinical guidelines and medical education evolve to keep pace with rapid evidence generation, AI can support real-time updates and manage complex information if transparency, reliability, and user-centered design remain central. Ultimately, AI should augment human judgment, reinforce evidence-based practice, and support clinicians in delivering high-quality, patient-centered care.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-A-26

Subject:	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
Presented by:	Padmini Ranasinghe, MD, MPH, Chair
Referred to:	Reference Committee E

American Medical Association (AMA) Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," which was adopted at the 2025 Annual Meeting by the AMA House of Delegates (HOD), and directs the following:

> That our American Medical Association collaborate with stakeholders, including physicians, academic institutions, and industry leaders, to create a report by A-26 with recommendations for how AI tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated.

This report serves as the Council on Science and Public Health's (CSAPH's) findings and recommendations after collaboration with key parties and review of the evidence surrounding transparency of evidence-based medicine in augmented intelligence (AI) tools for clinical decision-making.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "artificial intelligence", "augmented intelligence", "level of evidence", and "grading of evidence". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in AI, large language models, and medical information. Additional collaboration with the AMA Center on AI and Digital Health and other key parties was utilized to incorporate broad information.

BACKGROUND

AI-enabled decision support systems are rapidly evolving across sectors such as health care, business, and industrial operations to assist human decision-making by synthesizing complex data, making predictions, and offering evidence-based recommendations. In health care, clinical decision support systems now move beyond traditional rule-based alerts to include real-time evidence synthesis and large language model assistance, helping clinicians interpret patient data, identify high-risk cases, and recommend guideline-aligned interventions while preserving human judgment in final decisions. For example, modern platforms are used for medical imaging alerting and triage in radiology, such as systems that analyze CT scans to flag critical findings and can reduce diagnostic turnaround times and associated mortality.[1]

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AI decision support is also widely used in business and industry to forecast trends, optimize resource allocation, and support strategic planning through predictive analytics and prescriptive modeling integrated into enterprise systems.[2] These tools synthesize large datasets and provide decision frameworks that would be infeasible to process manually, improving strategic clarity and operational responsiveness.

Outcomes data for AI-assisted decision support shows promising signals with surveys indicating a growing adoption among clinicians with many reporting perceived improvements in care delivery, and some implementations have demonstrated measurable benefits such as enhanced guideline adherence and faster, more accurate identification of critical clinical events.[3] However, systematic evidence linking AI decision support directly to broad improvements in patient outcomes remains mixed, and many tools still lack validation across diverse real-world settings.[4]

Despite these advances, AI clinical decision support systems cannot replace human expertise - they are constrained by data quality, lack full transparency in reasoning, and are often assistive in nature rather than autonomous decision-makers.[5] In health care, opaque model logic and liability concerns persist. These limitations underscore ongoing challenges in trust, explainability, and regulation as AI continues to support rather than supplant human decision-making.[6]

Evidence-Based Medicine

Evidence-based medicine (EBM) is the cornerstone of clinical decision making in medical practice to provide the best patient outcomes. EBM utilizes rigorous scientific method and critical appraisal to organize and systematize the application of research and data to ground health care decisions.[7,8] By utilizing EBM, physicians are able to implement the most up-to-date scientific information into their practice while also building confidence in medical decisions and discussions with patients.

EBM application is a systematic process. EBM in clinical practice follows five steps: 1. Ask a searchable question; 2. Acquire information; 3. Appraise search results; 4. Apply the evidence in practice; and 5. Assess the provided care.[9] These five steps can be applied to each individual patient in each encounter and also to larger populations of patients in products such as clinical protocols and guidelines.[9] EBM is a key component in medical education to support evidence-based decision-making and these five steps are a framework for clinical teaching.

Levels of evidence play a vital role in evidence-based practice by providing a structured hierarchy for evaluating the quality and relevance of research. Typically illustrated as a pyramid, this framework helps clinicians make well-informed decisions by emphasizing studies with stronger methodologies and lower risk of bias (Appendix 1).[10] Grading systems translate the level of evidence into a commonly understood alphabetic system for hierarchical consumption and application (Appendix 2).[11,12] Clinical guidelines often utilize grading systems to demonstrate the strength of their recommendations based on the level of evidence used for their recommendations.[13,14] These grading systems help to support communication between patients and their physicians and ensure clear understanding of evidence-based practice for high quality care. There are multiple leveling or grading systems for use in EBM, each with their own challenges and drawbacks, particularly how the system can disadvantage certain study designs.[11] By understanding these levels, practitioners can ensure that their clinical decisions are grounded in the most reliable and rigorous evidence available. The integration of an EBM grading system into AI may support transparency but may be complex.

DISCUSSION

Transparency in AI refers to the accessibility and clarity of information about how an AI-enabled system is designed, trained, and makes decisions, such that key parties can understand and justify its behavior and outputs. At its core, transparency covers process-level elements (e.g., intended use, data sources, bias, model structure) and outcome-level explanations (e.g., why the system made a specific prediction), and is closely tied to explainability and interpretability as ethical principles in AI governance.[15,16]

The AMA's Council on Science and Public Health (CSAPH) Report 8-A-25, "Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms," underscores that while explainability is highly desirable (especially for augmented intelligence tools used in clinical care) it is also complex and nuanced, reflecting fundamental differences between algorithmic computation and human reasoning.[17] The report notes that explainability to build transparency is difficult to implement in practice and must be balanced with considerations such as safety, efficacy, and contextual expertise, and that explanations should be evaluated independently rather than relying solely on developer claims.[17]

Mechanisms

Building transparency includes embedding explainability into AI design (e.g., using inherently interpretable models or Explainable AI techniques like LIME and SHAP), documentation and reporting of data and model decisions, user-centered explanation interfaces, and third-party evaluation frameworks that assess explanation quality according to criteria like consistency, plausibility, fidelity, and usefulness.[18,19] At present, there is no single global standardization of transparency in AI; efforts such as principles in the EU AI Act and third-party explainability requirements in health care policy reflect emerging but fragmented standards across domains, and many organizations still lack universally accepted definitions or metrics for transparency.[20,21] Examples of how transparency is built into systems range from open-sourced models with clear documentation of training data and algorithms to clinical AI tools that generate feature attribution heatmaps showing which inputs most influenced a medical prediction, helping clinicians understand and verify outputs.[20] Ideas for improving transparency include adopting standardized explanation frameworks (e.g., model cards), multidisciplinary evaluation involving ethics and domain experts, embedding interpretability mechanisms during early model design, and enhancing communication tools so end users can meaningfully engage with AI reasoning.[22–25]

Challenges

Complex models like deep neural networks are often inherently opaque, presenting a black box problem that complicates transparency. A notable technical issue is "hallucinations" in generative AI, where models produce plausible sounding but incorrect outputs because they lack grounded reasoning tied to factual input data. Given that the industry standard term "hallucination" has specific behavioral health implications, we refer to this occurrence as a "confabulation" for this report.[26] Furthermore, transparency depends heavily on the quality and provenance of input data; datasets that are biased, incomplete, or poorly documented undermine meaningful explanation and increases the risk of misleading outputs.[27]

Many state-of-the-art AI models, especially deep learning and large transformer-based systems, are inherently highly complex and non-linear, with millions or even billions of parameters.[28] These internal representations do not map cleanly to human-understandable concepts, so tracing how an input leads to a specific output becomes extremely difficult even for the engineers who built them.

This "black box" opacity fundamentally limits transparency.[28] There is currently no universally accepted framework for what constitutes transparency or how to measure it reliably across applications. Some techniques produce local feature attributions, and others create surrogate models, but there is no consensus on which methods provide faithful or useful explanations.[29] This means that even when explanations are produced, they may be inconsistent, unvalidated, or misleading. There is no consensus on which methods provide faithful or useful explanations.

Many powerful AI systems are developed by private companies that protect their models and train data as trade secrets. This obscures key information about data provenance, processing steps, and architectural decisions, complicating independent audit or regulatory scrutiny.[30] Transparency is not only a technical issue but also a legal one. Even when explanation tools are used, they can inadvertently create a false sense of understanding. Explanations may oversimplify complex reasoning, leading users to over-trust AI outputs or misinterpret how decisions are reached. Some research suggests that explanations can increase human over-reliance on AI, even when AI is wrong, because explanations inflate perceived reliability without improving actual understanding.[31,32]

Generative AI models like large language models can produce outputs that are fluent and convincing but factually incorrect or fabricated, a phenomenon known as confabulation. Recognition of an AI confabulation is critical in the health care setting, where if not detected, it could cause harm to a patient.[33] These errors highlight a core transparency challenge: appearances of coherence does not guarantee truthfulness or logical validity, and users may mistake fluency for reliability.[34] Because confabulations emerge from the probabilistic nature of these models, they can be difficult to detect or explain post hoc.[20] Transparency is intimately tied to the quality and representativeness of input data. If training datasets are biased, incomplete, or poorly documented, explanations derived from these models may simply reflect those flaws, perpetuating hidden biases (e.g., demographic or cultural skew) that are difficult to uncover without transparent data reporting, and complicating ethical assessment and trust.[35]

Legal and governance frameworks for AI transparency are still evolving and vary significantly across jurisdictions.[30] Most health systems rely on vendor logs, institutional governance committees, and organizational policies to oversee how these technologies are used. Those approaches have worked reasonably well for earlier generations of clinical software. However, as the number of AI systems participating in clinical care grows, that model may outpace our ability to fully understand how these systems are involved in patient care. Regulatory uncertainty can discourage organizations from fully disclosing how their systems operate, and fragmented standards make cross-domain transparency difficult to implement consistently. Highly technical explanations may be accurate but remain incomprehensible to non-expert key parties, undermining transparency's goal of meaningful understanding for decision makers.[36]

As multiple AI systems begin to participate in a single patient visit, the profession will need visibility into that participation that is independent of vendor-controlled logs to preserve patient safety, physician accountability, and evidence-based care. Utilization of agentic AI is an emerging team member for many physicians working with AI in their clinical workflows.[37] If AI contributes to documentation, diagnostic suggestions, treatment recommendations, or other elements of the medical record, physicians and health systems need the ability to understand when those systems participated and how their outputs entered the clinical workflow. Maintaining that level of visibility will also help ensure that physicians remain aware of when AI contributes to patient care and that clear lines of human accountability for clinical decisions are preserved.

Current Upkeep of Clinical Recommendations and Training

Currently with AI, clinical guidelines support EBM in practice, with transparency of inputs and thorough analysis of the evidence for their recommendations. Typically clinical guidelines are developed and updated on a three to five year basis, with a latency period between when incorporation of newer evidence-based practice may lag.[38,39] With new research emerging daily, these time periods are at risk for quickly becoming outdated, with some research showing at least 20 percent of recommendations are outdated within three years of their publication.[40] AI poses possibility in this area with the ability to incorporate data inputs in a real time fashion, however without transparency or explainability capabilities, it is difficult to support clinical decision making in an evidence-based way.

Teaching EBM and training its implementation in practice is embedded into medical education. Originally as a mechanism to teach the skills necessary for information overload, something AI may be taking the workload of, EBM is an empirical approach for medical learners and practitioners to provide quality care and is highly embedded in medical education accreditation structures.[41,42] AI information and utility with best practices is emerging in medical education, similar to EBM decades ago.[42,43] With unclear transparency and explainability mechanisms, applying EBM structures and implementing them into medical education is challenging. Incorporating the intersection of EBM and AI tools, with their limitations and benefits of transparency and explainability, into medical education is prudent to prepare physicians for utilization of AI in their clinical decision-making.

CURRENT AMA POLICY

The AMA has extensive policy on AI in general. Several of these policies specifically discuss the need for transparency of AI used in clinical decision-making. Policy H-480.931, "Augmented Intelligence Development, Deployment, and Use in Health Care," outlined the regulatory landscape and AMA's historical role in AI governance. The section below briefly summarizes the most relevant portions of AMA policy.

H-480.931, "Assessing the Intersection Between AI and Health Care"

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce
- Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in

institutional settings, consistent with AMA Policy H-225.940, "Augmented Intelligence and Organized Medical Staff."

- When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
- Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
    - AI disclosure should align and meet ethical standards or norms.
    - Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
    - When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
    - When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
- Mitigating Misinformation in AI-Enabled Technologies
    - AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    - Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    - Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    - Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

D-480.954, "Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms"

- To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:

        - Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
        - To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
        - Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
        - Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
    - Our AMA will collaborate with experts and interested parties to develop, and disseminate a list of definitions for key concepts related to medical AI and its oversight.

H-480.939, "Augmented Intelligence in Health Care"

- Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
- Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    - clinical validation.
    - alignment with clinical decision-making that is familiar to physicians.
    - high-quality clinical evidence.
- There should be federal and state interagency collaboration with participation of the physician community and other key parties in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care key parties.

CONCLUSION

AI-enabled decision support systems are transforming how information is synthesized and applied across health care, business, and other sectors, offering rapid data analysis and evidence-informed recommendations that enhance, but do not replace, human expertise. In medicine, these tools show promise in improving efficiency, clinical workflow, and detection of high-risk conditions, yet their full impact on patient outcomes remains undetermined due to limited long-term validation and persistent concerns about transparency, bias, and explainability. EBM remains the foundation for trustworthy clinical decision-making and integrating its principles, such as graded evidence hierarchies and rigorous appraisal, into AI systems could strengthen confidence in integrating AI-enabled technologies into clinical care. However, significant challenges persist, including opaque model reasoning, inconsistent standards for transparency, a lack of transparency mandates in regulatory structures, and risks of confabulations in generative models. As clinical guidelines and medical education continue evolving to keep pace with rapid evidence generation, AI offers

substantial potential to support real-time updates and organize and analyze large amounts of information, provided that transparency, reliability, and user-centered design remain central. Ultimately, AI should be viewed as an augmenting tool that complements human judgment, reinforces evidence-based practice, and supports clinicians in delivering high-quality, patient-centered care.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA will:
    a. Recognize and promote the importance of transparency and explainability of AI tools used in clinical decision support to ensure the quality of medical evidence and the grading of medical evidence including the sources are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions.
    b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.
    c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making.
    d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care. (Directive to Take Action)

2. Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal note: Minimal

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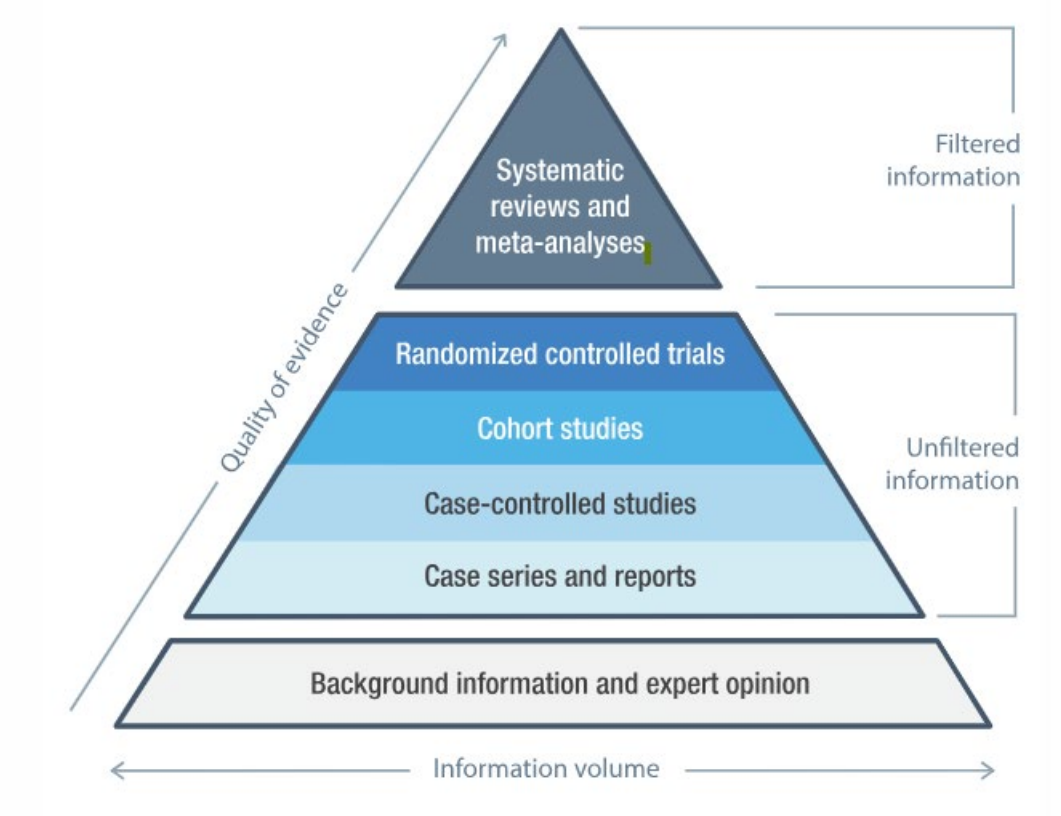
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APPENDIX

Appendix 1. Level of Evidence Pyramid[44]



Appendix 2. Level of Evidence and Grades of Recommendations[12]

Grade of Recommendation	Level of Evidence	Type of Study
A	1a	Systematic review of (homogeneous) randomized controlled trials
A	1b	Individual randomized controlled trials (with narrow confidence intervals)
B	2a	Systematic review of (homogeneous) cohort studies of "exposed" and "unexposed" subjects
B	2b	Individual cohort study / low-quality randomized control studies
B	3a	Systematic review of (homogeneous) case-control studies
B	3b	Individual case-control studies
C	4	Case series, low-quality cohort or case-control studies
D	5	Expert opinions based on non-systematic reviews of results or mechanistic studies

REPORT 8 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH
Increased Transparency Among Psychotropic Drug Administration in Prisons

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration in Prisons," requests that our AMA "study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness."

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "psychotropic medication," "drug administration," "carceral," "correctional," "prison," and "jail." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in carceral health care including the treatment of mental health disorders and medication management.

RESULTS. This report examines the administration of psychotropic medications in U.S. carceral settings, focusing on transparency, ethical standards, and continuity of care. Findings reveal significant variability in medication practices across federal and state prisons and jails, with limited standardized guidelines and oversight. While psychotropic medications are essential for managing mental health disorders, their use is often constrained by restrictive formularies, staffing shortages, and budget limitations that compromise continuity of care and equitable access to treatment. At the same time, rising prescription trends in jails underscore growing mental health needs, yet variability in policies and practices continues to create disparities. Policies governing involuntary medication lack uniformity, with many states omitting duration limits or independent review mechanisms, raising concerns about patient autonomy and due process. Overall, trends indicate a marked increase in psychotropic prescribing in jails over the past decade, particularly antipsychotics reflecting growing mental health needs but also highlighting systemic gaps in access, monitoring, and ethical safeguards.

CONCLUSION. Psychotropic medication use in carceral settings presents complex clinical, ethical, and operational challenges that demand greater transparency and evidence-based oversight. While these medications are essential for managing mental health disorders, their administration must adhere to rigorous standards of assessment, informed consent, and ongoing monitoring to prevent misuse as a means of control. Addressing these challenges will require policy reforms that strengthen oversight, standardize care protocols, expand affordable drug access, and ensure that carceral settings uphold constitutional and ethical obligations to provide safe, humane, and clinically appropriate treatment.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 8-A-26

Subject: Increased Transparency Among Psychotropic Drug Administration in Prisons

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee E

American Medical Association (AMA) Policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration in Prisons," adopted at the 2025 Annual Meeting directs the following:

1. Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.
2. Our AMA supports increased transparency from jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

This report examines the use of psychotropic medications in carceral settings (i.e., jails and prisons) including drug formulary considerations, evidence-based policies, as well as the legal right to health care for individuals in carceral settings.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "psychotropic medication," AND "carceral," OR "correctional," OR "prison," OR "jail"; "drug administration," AND "carceral," OR "correctional," OR "prison," OR "jail". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in carceral health care including the treatment of mental health disorders and medication management.

BACKGROUND

The U.S. has the largest incarcerated population in the world with over 2 million people in carceral settings.[1] Individuals in jails and prisons have a higher rate of chronic conditions, substance use, and mental health disorders when compared to the general population.[2] A national survey reported that in the U.S. "there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals;" some states, such as Arizona and Nevada, had almost 10 times more.[3] A 2019 report found that 52 percent of those arrested two or more times reported a substance use disorder in the past year and 25 percent of people with multiple arrests reported having a serious mental illness (See Appendix 1).[4] Mental health courts and other deflection

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programs serve as a mechanism to link eligible individuals to court-supervised, community-based treatment. AMA policy is supportive of diversion programs including mental health courts and drug courts to direct people to treatment programs in the community, but these are outside of the scope of this report. Deflection programs, immigration detention, and juvenile detention centers are also beyond the scope of this report.

The most recent government report and survey of incarcerated individuals compiled information from 233 state and federal prisons, 358 jails, and 15 special facilities (military, Indian country, and Immigration and Customs Enforcement facilities).[5] Nearly a quarter (24 percent) of the prisoners who had ever been told they had a mental disorder had major depressive disorder, 18 percent had bipolar disorder, 13 percent had post-traumatic stress disorder (PTSD) or a personality disorder; and 9 percent had schizophrenia or another psychotic disorder.[5] With the exception of personality disorder, local jail inmates were more likely than state prisoners to have been told they had each type of mental health disorder.[5] Studies also indicate that 60–87 percent of people in carceral settings have co-occurring mental health and substance use disorders (CODs).[6,7] However, few existing specialized COD treatment programs have been developed for carceral settings, in part due to the lack of integrated treatment programs in carceral settings.[8] Appropriate psychotropic medications are an effective intervention for treating mental health disorders and are generally the standard of care, particularly for serious mental illness.

DISCUSSION

Mental Health Disorder Screening

Timely psychiatric assessment is essential to prevent psychiatric deterioration following arrest, yet formal guidelines remain limited.[10,11] Best practices recommend screening for high-risk conditions during medical intake and prioritizing rapid evaluation for individuals with serious mental illness, prior hospitalizations, or suicidal behavior.[11] National Commission on Correctional Health Care (NCCHC) standards note that "screening may be done by qualified mental health professionals or by mental health staff, and when the results are positive for mental health problems, the inmate must be referred to qualified mental health professionals (e.g., psychiatrist, psychologist, psychiatric nurse, psychiatric social worker) for further evaluation."[12,13] Research shows that individuals screened for mental health conditions at intake are significantly more likely to be evaluated by a medical professional, which in turn increases the likelihood of receiving consistent pharmacologic treatment for their condition.[9]

Psychotropic Medications

Psychotropic medications are drugs that alter neurotransmitter activity at synapses in the brain and are the cornerstone of treatment for mental health disorders. They are often used to treat and manage behavioral and psychiatric symptoms.[14] There are five major categories of psychotropic medications: (1) antipsychotic medications; (2) antidepressants; (3) anxiolytic medications; (4) stimulants; and (5) mood stabilizers (See Appendix 2 for common psychotropic medications).[15–17]

In addition to providing relief to specific symptoms of mental health disorders, psychotropic medications have adverse side effects including producing a sedative effect, tardive dyskinesia, muscular rigidity, seizures, depression, or increased risk of suicide.[15,33] Inappropriate administration of psychotropic medications can further impair functioning. Although advances in the psychopharmacological field have produced a new generation of psychotropic drugs that result in less adverse side effects, most prisons employ the older medications which are less expensive.[34,35]

Use and Prevalence of psychotropics in prisons and jails

Individuals in carceral settings often face significant barriers to receiving or continuing psychotropics for mental health conditions.[2] Barriers to receiving or continuing psychotropics include a shortage of qualified psychologists and psychiatrists, reliance on screening tools designed primarily for security risk rather than diagnostic accuracy, limited carceral budgets that prioritize only the most severe cases, and the high cost and logistical difficulties associated with off-site specialized programs.[9] Additionally, research on psychotropic medication use among those in carceral settings remains limited, partly because this population is a protected research class.

The prevalence of psychotropic prescribing in carceral settings is substantially elevated compared to the community, with recent data showing significant increases across all medication classes from 2013 to 2023, including a 249 percent increase in antipsychotic prescriptions.[18] Women in prison receive psychotropic medications at particularly high rates (47.9 percent), approximately six times higher than the general population.[19] There are multiple key considerations related to the use of psychotropic medications, particularly in carceral settings.

The states with the highest percentage of prison inmates receiving psychotropic medication report that approximately 20 percent of their inmates were on such medications.[20] In Louisiana, Maine, Nebraska and Wyoming at least one in four inmates participated in mental health therapy or counseling programs.[20] In Nebraska state prisons specifically, 56 percent of inmates suffer from a mental illness, 16 percent have a serious mental illness, and 25 percent of male inmates and 50 percent of female inmates are prescribed psychotropic medications.[21] Only three states, North Dakota, Rhode Island, and Wyoming, lack dedicated psychiatric facilities and instead place prisoners who require mental health treatment in state hospitals, prison infirmaries, or in special needs units within general confinement facilities.[20] However, this data is from 2000-2001 data, and there is a need for updated studies in a field where pharmacologic and administrative processes are rapidly progressing.

Recent data shows a shift towards the increased use of medications in jails. [23-24] An analysis of psychotropic prescribing trends in 34 jails over an 11-year period (2013–2023), based on data from more than 1.25 million detainees' health records, revealed a significant increase in medication use over time (See Appendix 3).[25] Similarly, a study that assessed prescription patterns for individuals before and after COVID-19 in 18 county and municipal jails found that prescription patterns in all major therapeutic drug classes steadily increased, with 10 percent more people prescribed at least one drug post COVID-19 in 2023, despite the jail census decreasing over this time.[26] Prescription increases were observed across central nervous system medications including antipsychotics, antidepressants, and antianxiety medications (See Appendix 4).[26]

Medication Administration, Continuity, and Monitoring

Psychotropics, particularly selective serotonin reuptake inhibitors (SSRIs) or selective norepinephrine reuptake inhibitors (SNRIs), can take up to 12 weeks of administration to achieve efficacy and conversely may cause significant withdrawal symptoms if abruptly stopped.[27] Continuity of psychotropic medications in carceral settings is less than optimal, with reports of more than 50 percent of those on psychotropics for mental health disorders not receiving them while in prison.[9] The NCCHC standard requires that individuals entering a correctional facility continue receiving their clinically indicated prescription medications without interruption, unless a qualified clinician determines a justified change.[28]

Coordination and continuity of care are often disrupted for a multitude of reasons in prisons and jails, such as inadequate screening, lack of health professional staff, and inmate refusal – this can

lead to the people in carceral settings being under prescribed psychotropic medications that they were previously prescribed.[9,29] Maintaining continuity of psychotropic medications in carceral settings is a persistent challenge. During intake, transfers, or initial health assessments, incarcerated individuals often cannot provide complete or accurate details about their medication history—such as drug names, dosages, and schedules.[10] Records from community providers and pharmacies rarely accompany them, and obtaining these records typically requires a signed release of information.[10] Intake staff may attempt to verify prescriptions by contacting community pharmacies, but delays are common. While electronic medical records can enhance communication, the lack of interagency agreements for sharing of information often delays verification of medications, diagnoses, and recent treatment dates.[10]

In jails, where stays are typically short, strategies such as "bridge orders" can help maintain continuity of care by temporarily continuing outpatient medications until a psychiatrist can conduct an evaluation.[11] These orders should be time-limited and supported by collateral information from pharmacies, community providers, or family members to ensure accuracy and expedite appropriate treatment.[11]

Administration of psychotropics often requires significant monitoring, such as electrolytes, renal function, and cardiac monitoring for safety.[30,31] Ongoing assessment of prescription effects are essential to evaluate therapeutic response, detect adverse effects, and adjust treatment plans as clinically indicated. Certain antipsychotics are subject to additional monitoring through Risk Evaluation and Mitigation Strategies (REMS) programs, a Food and Drug Administration (FDA) mandated safety program required for medications that carry serious risks.[32] These additional monitoring requirements limit access to these agents in carceral settings.

Continuity of care, including discharge planning, is equally important to reduce health risks. Discharge planning should include providing enough medication or refills until the patient sees a community provider, using affordable and widely available psychotropics, and considering long-acting formulations.[10] For those on parole, coordination with parole departments can make adherence to mental health treatment a condition of release.[10] Additionally, the release dates for people in local jails are often unpredictable posing significant challenges to discharge planning. These have the potential to be mitigated through bridge prescriptions, rapid medication verification, expedited linkage to care. Medicaid re-enrollment on discharge and telehealth handoffs to community healthcare providers can support the continuity of psychotropic care. When a lack of discharge planning and continuity of care are not executed well this can lead to increased risk of psychiatric decompensation, return to illicit substance use, overdose, and suicide.

Involuntary Administration

Incarceration does not alter the fundamental medical, ethical, or legal requirements for informed consent, and therefore the involuntary administration of psychotropic medications in carceral settings raises significant clinical and ethical concerns. Most available information on the use of psychotropic medications to control, rather than treat, incarcerated individuals comes from inmate self-reports and human rights organizations, as carceral institutions rarely disclose intentional use of psychotropic medications for coercion or control.[33] It is important to distinguish evidence-based psychiatric treatment, delivered to address a diagnosed mental health disorder, from pharmacologic behavioral management used primarily for institutional convenience or security. Chemical restraint, even when framed as treatment, is governed by distinct ethical and clinical standards and requires heightened justification, procedural safeguards, and oversight. Health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be

ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient (See Code of Medical Ethics 1.2.7 Use of Restraints and CSAPH Report 4, A-25).
An analysis of state Department of Corrections (DOC) and Federal Bureau of Prisons (BOP) policies related to mental health found that 35 out of the 36 states (97 percent) with publicly available information allowed the involuntary use of psychotropic medications in emergency situations; this correlates to 76 percent (one million) of the total incarcerated population in the U.S (See Appendix 5).[36] Additionally, state policies vary widely in both the allowable types and maximum duration of involuntary psychotropic medications; while some states specify these limits in statute or policy, others provide no guidance at all (See Appendix 6).[36] Many laws and policies lack mechanisms for independent review or appeals, effectively placing decisions about treatment in the hands of individuals who may not be mental health professionals.[36]

There are also ethical considerations as carceral facilities may justify involuntary sedation arguing that the policy is necessary for the safety of others in the prison environment.[37] The American Psychiatric Association (APA) states that non-emergency involuntary administration of psychotropic medication in jails presents a complex ethical dilemma, balancing beneficence—the obligation to alleviate suffering and restore functioning—against autonomy, the right of individuals to make decisions about their own care.[38] While such treatment can reduce symptoms, prevent harm of the prisoner and others, and improve outcomes such as reducing disciplinary infractions and facilitating legal resolution, it also carries significant risks.[38] Involuntary medication should only occur after reasonable attempts at voluntary engagement have failed, under strict procedural safeguards, and with adequate clinical oversight.[38] Where clinically appropriate, psychiatric hospitalization should remain an alternative to ensure patient safety and uphold ethical standards.[38]

Psychotropic administration challenges

There are variabilities in medication practices across carceral settings. A survey of 51 county jails in Missouri found that most jails (74 percent) never charged a fee for medication administration, while 22 percent always did, creating potential barriers for individuals without income or Medicaid eligibility.[23] While some states permit correctional officers to administer medications dispensed from the pharmacy, the NCCHC advises that these staff receive specialized training in security, accountability, side effects, and documentation.[10] In a state survey of 51 county jails in Missouri, 57 percent of jails could administer long-acting injectable antipsychotics, and 49 percent performed weekly lab tests.[23]

In the 51 Missouri jails, medication restrictions were common — 11 jails refused all controlled substances, 16 excluded benzodiazepines, and 20 excluded opioids.[23] Additional limitations included quetiapine, gabapentin, bupropion, and trazodone.[23] Many jails did not allow individuals to use their own medications upon discharge from psychiatric facilities.[23] Despite the benefits of LAIAs for treatment, oral medications were preferred due to cost and logistical challenges, especially in facilities lacking on-site medical staff.[23] It is important to note that this is a state specific example and the generalizability to other states is unknown. However, these findings highlight significant gaps in access and continuity of psychiatric care in jails, with financial and operational barriers limiting evidence-based treatment. [23]

Psychotropic drugs are rarely classified as “keep on person,” where incarcerated persons can maintain their own medications, due to concerns about adherence and misuse. Medication diversion represents a significant security concern, necessitating direct observation of medication administration and careful monitoring of controlled substances.[39] While certain state DOC settings have allowed lower-risk psychotropic medications to be self-administered on a case-by-case basis,

at least one system discontinued this practice after discovering that patients were "hoarding" medications for nonmedical purposes.[10]

Drug Formulary Considerations

Drug formularies in carceral settings play a critical role in incarcerated patients' access to psychotropic medications, imposing significant restrictions on treatment options, often to lower cost by providing older medications. Over one-quarter (28 percent) of jails have a formulary. For example, the California Correctional Health Care Services formulary bans or limits access to at least 14 commonly used psychiatric medications, including bupropion, quetiapine, gabapentin, and hydroxyzine.[40] While formulary restrictions can limit access to certain psychotropic medications, they may also serve clinical and security purposes, as some commonly restricted agents carry significant potential for misuse, underscoring that such policies can present both benefits and harms. A review of jail formularies in Texas revealed significant variability in practices, driven primarily by local decision-making rather than medication cost.[40] The Pharmacy and Therapeutics Committee in carceral settings oversees medication management by maintaining the formulary and reviewing requests for nonformulary medications.[10]

There are significant policy-level barriers to pharmaceutical purchasing in carceral systems, notably the restrictions on Medicaid coverage.[41,42] Few jails offer the same range of medications available in state hospitals, and omissions often include inexpensive and commonly used drugs. In some cases, facilities include costly antipsychotics while excluding essential, lower-cost options.[43] These inconsistencies highlight the absence of standardized formulary policies and raise concerns about equitable access to evidence-based psychiatric care as well as unnecessary elevations in cost.[43] Similar restrictions appear in the BOP national formulary, which also limits medications like fluoxetine and venlafaxine, two of the most commonly used antidepressant medications.[40] The BOP allows temporary use of nonformulary medications for up to four days if withholding them would pose a significant risk to the patient.[40] However, determinations of what constitutes a 'significant risk' are inherently subjective and treatment options may depend more on formulary rules than on clinical need or appropriateness of the medication, raising concerns about equitable access to care.[40]

Carceral Health Care Staff and Oversight

The composition of health care teams in carceral facilities varies by facility size and inmate population. Larger institutions often employ multidisciplinary teams, while smaller facilities may rely on a single clinician with specialty care delivered on-site through contracted physicians, telehealth, or off-site referrals. Despite financial incentives state prisons have lost 12 percent of their full-time workforce over the past decade, with most of the decline occurring during the pandemic, while local jails experienced a smaller but notable reduction (7 percent).[44] The APA recommends one prescriber for every 75 to 100 patients with serious mental illness on psychotropic agents in jails, and one prescriber for every 150 such patients in prisons.[45] However, many facilities face persistent staffing shortages utilizing psychologists in place of physicians. Physicians are needed for oversight and to prescribe psychotropic medications because safely managing these powerful drugs requires extensive medical training in physiology, pharmacology, diagnosis, and the management of complex comorbid conditions that psychologists and other non-medical professionals do not receive.[46]

CURRENT AMA POLICY

Our AMA maintains a broad set of policies relevant to this report, including support for diversion programs (H-100.955 "Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs"), support for the provision of adolescent health care within detention and correctional facilities (H-60.986, "Health Status of Detained and Incarcerated Youth"), and justice reinvestment initiatives (H-95.931, "AMA Support for Justice Reinvestment Initiatives").

Additional policies address drug safety and REMS (H-100.961, "The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)"), behavioral health emergency practices in carceral settings (H-345.969, "Carceral Systems and Practices in Behavioral Health Emergency Care"), prevention of unnecessary hospitalization or jail confinement (H-345.995, "Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill"), and mental health crisis interventions (H-345.972, "Mental Health Crisis Interventions").

The AMA also supports access to health care while incarcerated (H-430.986, "Health Care While Incarcerated") and standards of care for correctional facilities (H-430.997, "Standards of Care for Inmates of Correctional Facilities"). Further policies include guidance on medications for opioid use disorder (H-430.987, Medications for Opioid Use Disorder in Correctional Facilities"), minimum requirements for medication formularies (H-110.958, "Minimum Requirements for Medication Formularies"), and best practices for acute care of patients in law enforcement or correctional custody (D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections").

In efforts to improve the administration of psychotropic medications, in 2024 AMA released "Psychopharmacology How-To Guide," which offers primary care physicians practical strategies and evidence-based resources on when and how to treat patients with psychotropic medications if deemed medically necessary.[47] This is part of AMA's efforts to improve health care by overcoming obstacles to accessible and equitable treatment for patients' behavioral, mental, and physical health needs.

CONCLUSION

Psychotropic medication use in carceral settings presents complex clinical, ethical, and operational challenges that demand greater transparency and evidence-based oversight. While these medications are essential for managing mental health disorders, their administration must adhere to rigorous standards of screening and assessment, informed consent, and ongoing monitoring to prevent misuse and improve outcomes. Involuntary treatment, though sometimes clinically necessary, raises profound ethical concerns and procedural safeguards should be in place to balance beneficence with autonomy. Systemic barriers, including inconsistent formularies, staffing shortages, and opaque pharmaceutical purchasing processes, further compromise continuity of care and equitable access to psychotropic medications and treatment.

RECOMMENDATION

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration," be amended by addition and deletion to read as follows:

   A. ~~Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.~~

   Our AMA supports increased transparency from jails and prisons surrounding mental health care, including utilization ~~protocols pertaining to the administration~~ of psychotropic medications, and corresponding patient outcomes, potential harms, and system challenges. ~~including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.~~

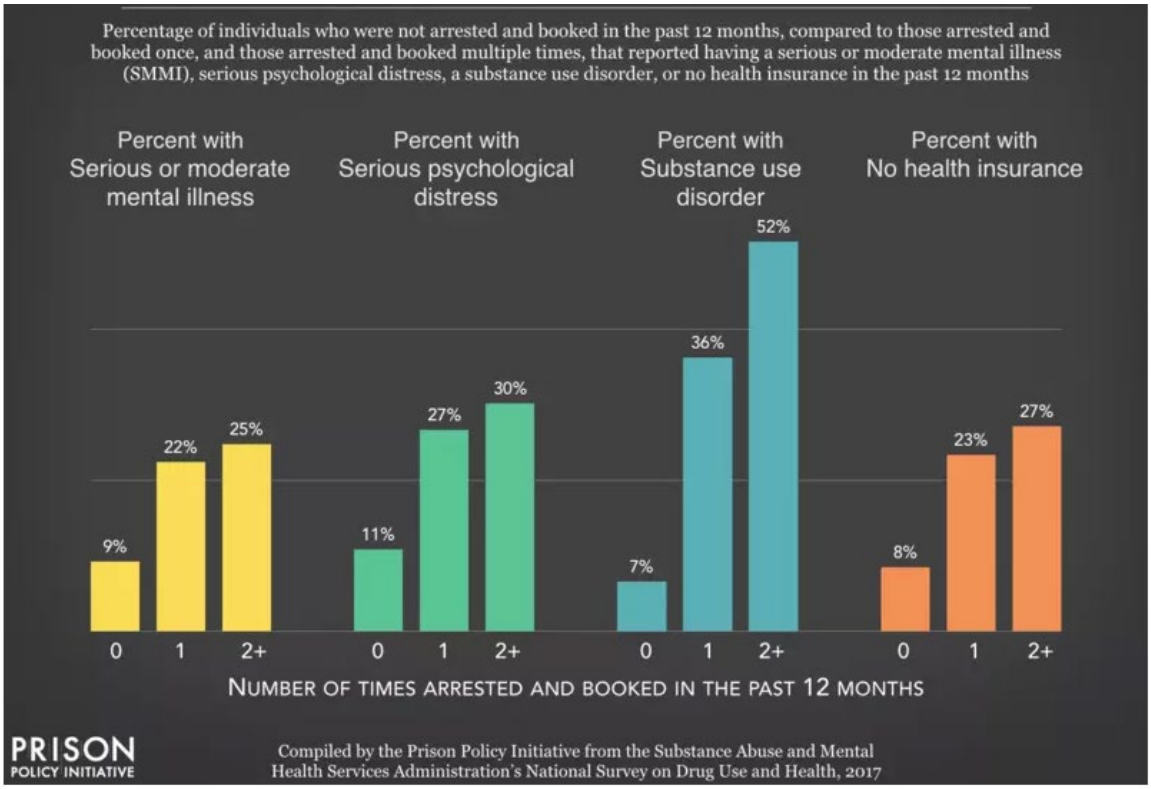
   B. Our AMA acknowledges the importance of continuity of care for mental health disorders in carceral settings and encourages incorporation of programs and procedures to promote evidence-based continuity of care, including bridge programs, medication verification protocols, access to qualified physicians, and post-release linkage to community clinics for continued care. (Modify Current HOD Policy)

2. That our AMA reaffirm the following HOD policies:

   H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" H-430.986, "Health Care While Incarcerated;" D-430.997, "Support for Health Care Services to Incarcerated Persons;" and H-110.958, "Minimum Requirements for Medication Formularies." (Reaffirm HOD Policy)

Fiscal Note: Minimal

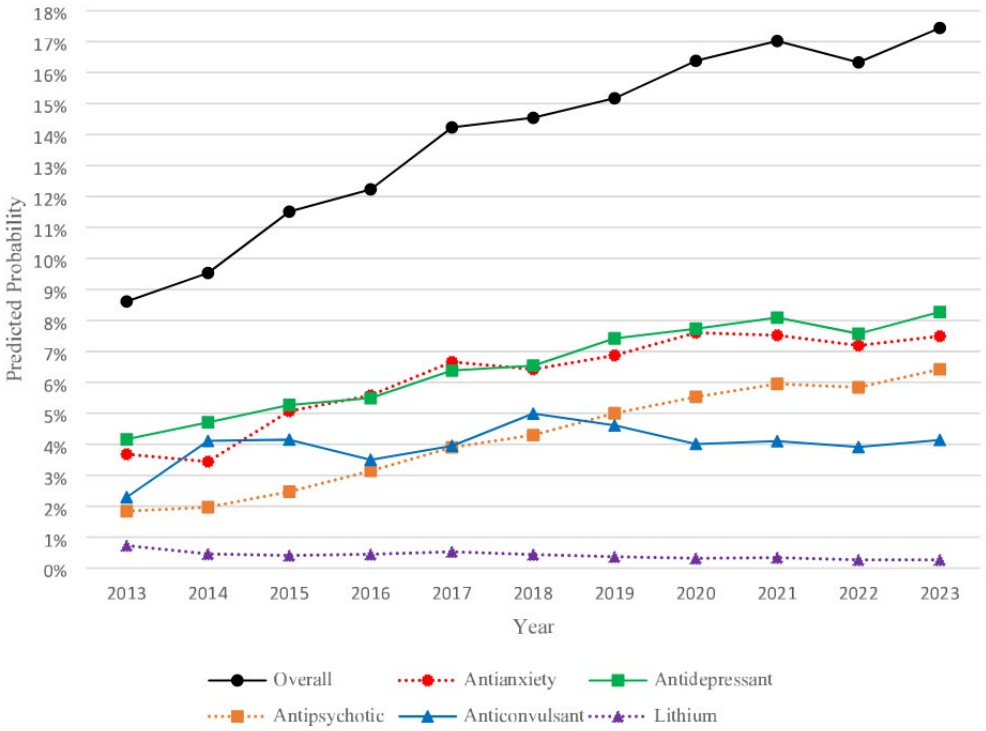
APPENDIX 1. People with Multiple Arrests that have Serious Health Needs[4]



APPENDIX 2. Common Psychotropic Medications, Their Indications, and Considerations[30,31,48–57]

Class	Examples	Typical Dosing	Primary Indications	Key Side Effects	Monitoring
SSRIs	Sertraline, Escitalopram, Fluoxetine, Citalopram, Paroxetine	Sertraline: 50-200 mg/day; Escitalopram: 10-20 mg/day; Fluoxetine: 20-80 mg/day; Citalopram: 20-40 mg/day	Depression, anxiety disorders	GI symptoms, sexual dysfunction, hyponatremia, insomnia; Citalopram: QTc prolongation	Hyponatremia risk (especially with thiazides), bleeding risk with anticoagulants
SNRIs	Venlafaxine, Duloxetine, Desvenlafaxine	Venlafaxine: 150-375 mg/day; Duloxetine: 60-120 mg/day; Desvenlafaxine: 50 mg/day	Depression, anxiety, neuropathic pain	Hypertension, tachycardia, GI symptoms, sexual dysfunction, increased sweating	Blood pressure (especially venlafaxine >300 mg/day), lipids
Atypical Antidepressants	Bupropion, Mirtazapine, Trazodone	Bupropion: 300-450 mg/day; Mirtazapine: 15-45 mg/day; Trazodone: 150-500 mg/day	Depression, insomnia (trazodone)	Bupropion: insomnia, anxiety; Mirtazapine: sedation, weight gain; Trazodone: sedation, priapism	Bupropion: seizure risk; Trazodone: QTc, orthostatic hypotension
Tricyclic Antidepressants	Amitriptyline, Nortriptyline, Desipramine	Amitriptyline: 25-300 mg/day; Nortriptyline: 25-150 mg/day; Desipramine: 25-300 mg/day	Depression, neuropathic pain	Anticholinergic effects, sedation, weight gain, orthostatic hypotension, arrhythmias	ECG, avoid in ischemic heart disease; therapeutic drug levels for nortriptyline
Second-Generation Antipsychotics	Risperidone, Quetiapine, Aripiprazole, Olanzapine, Lurasidone	Risperidone: 0.25-6 mg/day; Quetiapine: 150-800 mg/day; Aripiprazole: 2-30 mg/day; Olanzapine: 5-20 mg/day	Schizophrenia, bipolar disorder, augmentation for depression	Metabolic syndrome (weight gain, hyperglycemia, dyslipidemia), sedation, EPS, hyperprolactinemia, QTc prolongation	Baseline and periodic: BMI/waist circumference (monthly x3, then at 6 mo, yearly), fasting glucose/HbA1c, lipids; AIMS for tardive dyskinesia
Mood Stabilizers	Lithium, Valproate	Lithium: 600-1,200 mg/day; Valproate: variable	Bipolar disorder, augmentation for depression	Lithium: tremor, polyuria, hypothyroidism, renal impairment; Valproate: weight gain, sedation, hepatotoxicity, teratogenicity	Lithium: levels (0.6-1.2 mEq/L), renal function, thyroid; Valproate: levels, LFTs, CBC
Stimulants	Methylphenidate, Amphetamines	Methylphenidate: variable; Amphetamines: variable	ADHD, narcolepsy	Decreased appetite, insomnia, cardiovascular effects, growth suppression in children	Blood pressure, heart rate, growth parameters in children
Anxiolytics/Hypnotics	Benzodiazepines, Z-drugs	Variable by agent	Anxiety, insomnia	Sedation, dependence, cognitive impairment, falls	Assess for dependence, falls risk in elderly

APPENDIX 3. Predicted Probabilities of Prescribed Psychotropic Medications by Year[25]



APPENDIX 4. Prevalence Estimates and Demography of Individuals Prescribed Select Pharmaceutical Agents / Products by Year[26]

	Year				
GPI therapeutic class	*2019* N = *17,607*	*2020* N = *12,158*	*2021* N = *14,249*	*2022* N = *15,125*	*2023* N = *16,062*
Analgesic and anesthetics					
# Individuals prescribed agent	1,142 (6.5)	988 (8.1)	1,162 (8.2)	1,420 (9.4)	1,630 (10.2)
Total agents prescribed	1,233	1,086	1,268	1,578	1,852
Drug class					
Analgesics—narcotics	241 (1.4)	218 (1.8)	336 (2.4)	536 (3.5)	541 (3.4)
Analgesics—non-narcotics	446 (2.5)	467 (3.8)	521 (3.7)	541 (3.6)	645 (4.0)
Antirheumatic	497 (2.8)	350 (2.9)	336 (2.4)	440 (2.9)	574 (3.6)
Gout	29 (0.2)	34 (0.3)	36 (0.3)	34 (0.2)	56 (0.3)
Age, years					
15–19	8 (0.7)	9 (0.9)	7 (0.6)	19 (1.3)	14 (0.9)
20–34	404 (35.4)	355 (35.9)	390 (33.6)	538 (37.9)	559 (34.3)
35–54	515 (45.1)	437 (44.2)	526 (45.3)	639 (45.0)	777 (47.7)
55+	215 (18.8)	187 (18.9)	239 (20.6)	224 (15.8)	280 (17.2)
Sex * Race					
Female	193 (16.9)	98 (9.9)	137 (11.8)	189 (13.3)	282 (17.3)
Black	34 (3.0)	30 (3.0)	30 (2.6)	33 (2.3)	72 (4.4)
White	133 (11.7)	54 (5.5)	95 (8.4)	121 (8.5)	152 (9.3)
Other	5 (0.4)	4 (0.4)	3 (0.3)	8 (0.6)	8 (0.5)
Unknown	21 (1.8)	10 (1.0)	9 (0.8)	27 (1.9)	50 (3.1)
Male	949 (83.1)	889 (90.1)	1,025 (88.2)	1,231 (86.7)	1,348 (82.7)
Black	416 (36.4)	428 (43.3)	454 (39.1)	479 (33.7)	592 (36.3)
White	427 (37.4)	374 (37.9)	465 (40.0)	529 (37.3)	562 (34.5)
Other	18 (1.6)	12 (1.2)	25 (2.2)	34 (2.4)	28 (1.7)
Unknown	88 (7.7)	76 (7.7)	81 (7.0)	189 (13.3)	166 (10.2)
Central nervous system					
# Individuals prescribed agent	4,526 (25.7)	3,917 (32.2)	4,797 (33.7)	4,878 (32.3)	5,212 (32.5)
Total agents prescribed	8,848	8,300	9,734	9,610	10,214
Drug class					
Antianxiety	1,508 (8.6)	1,319 (10.8)	1,525 (10.7)	1,425 (9.4)	1,682 (10.5)
Antidepressant	3,291 (18.7)	2,910 (23.9)	3,457 (24.3)	3,479 (23.0)	3,685 (22.9)
Antipsychotic	2,375 (13.5)	2,149 (17.7)	2,670 (18.7)	2,675 (17.7)	2,840 (17.7)
Hypnotics	5 (<0.1)	5 (<0.1)	3 (<0.1)	4 (<0.1)	4 (<0.1)
Lithium	141 (0.8)	110 (0.9)	122 (0.9)	105 (0.7)	121 (0.8)
Stimulants	3 (<0.1)	5 (<0.1)	7 (<0.1)	7 (<0.1)	11 (<0.1)
Miscellaneous psychotherapeutics	9 (0.1)	9 (0.1)	7 (<0.1)	11 (0.1)	5 (<0.1)
Age, years					
15–19	102 (2.3)	101 (2.6)	112 (2.3)	114 (2.3)	105 (2.0)
20–34	2,031 (44.9)	1,862 (47.5)	2,204 (45.9)	2,253 (46.2)	2,262 (43.4)
35–54	1,953 (43.2)	1,630 (41.6)	2,055 (42.8)	2,056 (42.1)	2,348 (45.0)
55+	440 (9.7)	324 (8.3)	426 (8.9)	455 (9.3)	497 (9.5)
Sex * Race					
Female	978 (21.6)	683 (17.4)	725 (15.1)	822 (16.9)	1,035 (19.9)
Black	214 (4.7)	170 (4.3)	192 (4.0)	221 (4.5)	373 (7.2)
White	698 (15.4)	481 (12.3)	492 (10.3)	535 (11.0)	581 (11.2)
Other	25 (0.6)	12 (0.3)	11 (0.2)	25 (0.5)	24 (0.5)
Unknown	41 (0.9)	20 (0.5)	30 (0.6)	41 (0.8)	57 (1.1)
Male	3,548 (78.4)	3,234 (82.6)	4,072 (84.9)	4,056 (83.1)	4,177 (80.1)
Black	1,431 (31.6)	1,467 (37.5)	1,803 (37.6)	1,831 (37.5)	1,915 (36.7)
White	1,897 (41.9)	1,585 (40.5)	2,009 (41.9)	1,897 (38.9)	1,915 (36.7)
Other	101 (2.2)	79 (2.0)	93 (1.9)	112 (2.3)	113 (2.2)
Unknown	119 (2.6)	103 (2.6)	167 (3.5)	216 (4.4)	234 (4.5)

APPENDIX 5. State Policies on Emergency and Non-Emergency Administration of Psychotropic Medications[36]

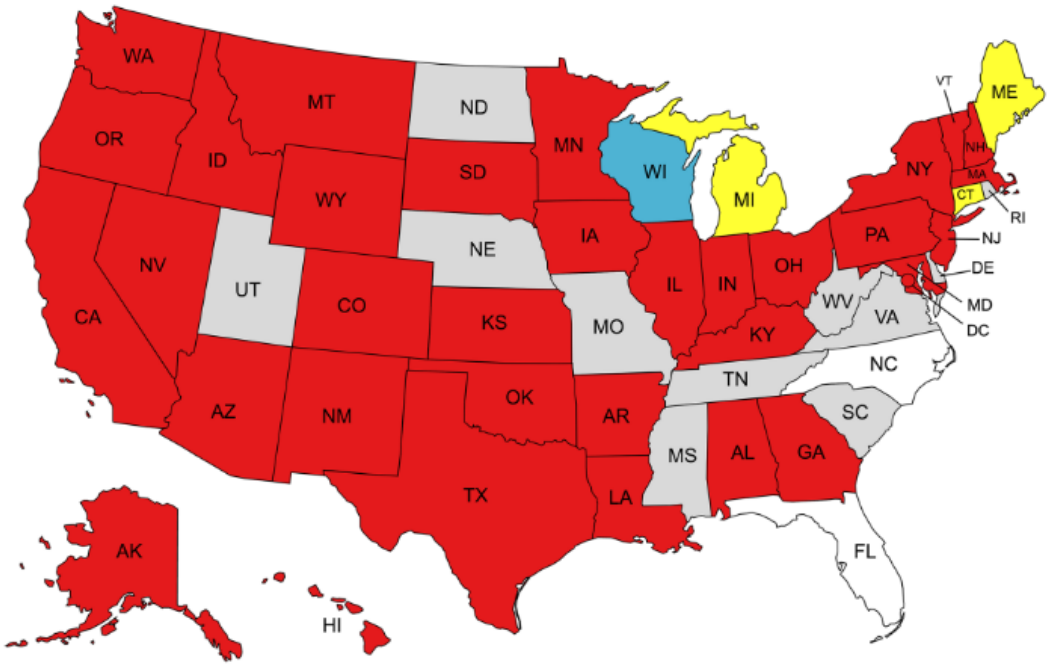
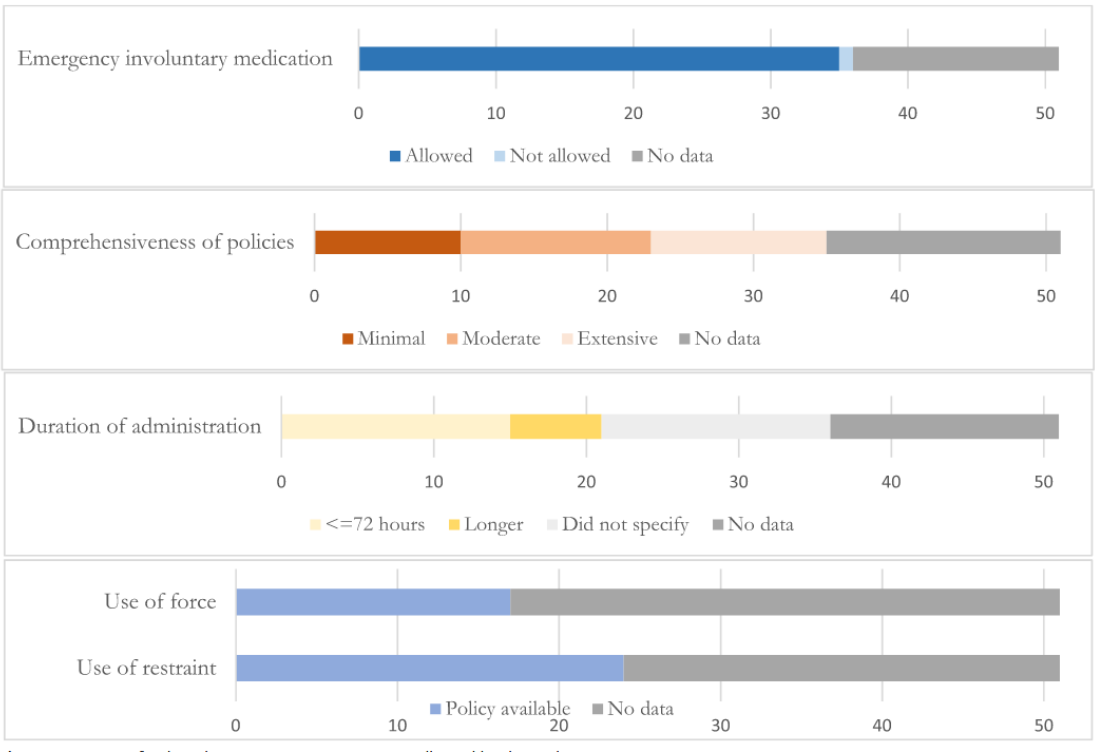


Fig. 1 Policies regarding emergency and non-emergency involuntary administration of psychotropic medication across the United States. Federal Bureau of Prisons is represented by District of Columbia (DC). Red = available policies on involuntary administration of psychotropic medication explicitly allow use in emergency situations, Blue = available policies on involuntary administration of psychotropic medication allow use in non-emergency situations, but do not specify use in emergency situations, Yellow = available policies on involuntary administration of psychotropic medication do not distinguish between emergency and non-emergency use, Gray = no policy data or insufficient data, White = excluded from analysis due to withdrawn policy or limited in scope. Source: Data collected by the authors; map created in mapchart.net

APPENDIX 6. Summary of State Policy Characteristics for the Use of Psychotropic Medications[36]



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REPORT 9 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
In Support of a National Drug Checking Registry

EXECUTIVE SUMMARY

BACKGROUND. Policy D-95.950, "In Support of a National Drug Checking Registry" as adopted by the House of Delegates at 2025 Annual Meeting and asked that our AMA "study the creation of a national drug-checking data system that would provide a mechanism whereby community-run drug-checking services may communicate their de-identified results, with legal protections, data use agreements, and user opt-in/opt-out mechanisms."

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "drug checking." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in community drug checking, data collection, and legal protections of public health data.

DISCUSSION. Drug checking programs across the United States (U.S.) provide valuable, timely insights into the evolving illicit drug supply, using a range of technologies, from inexpensive test strips to advanced spectrometry, to detect adulterants including unexpected or novel psychoactive substances. These programs have demonstrated measurable effects on participant attitudes and intended behaviors, with many individuals reducing doses, modifying practices, consuming more slowly, using test shots, or disposing of contaminated substances after receiving unexpected results. Multiple states, including Michigan, Illinois, Rhode Island, and North Carolina, have shown that drug checking and dashboards are both feasible and valuable, providing timely insight into local drug markets and supporting more informed public health responses. As these systems continue to expand, the challenge is how to scale such models in ways that are ethical, safe, and responsive to the needs of diverse populations and stakeholders. This report highlights significant legal variability across states regarding the possession, distribution, and use of drug checking equipment, creating ongoing barriers to scaling these services nationally. Finally, existing data systems, funding structures, and public health frameworks illustrate both the usefulness of drug checking data and the need for stronger, more consistent protections, governance models, and infrastructure to support emerging statewide and multistate dashboards.

CONCLUSION. Despite their promise, national drug checking efforts face substantial feasibility barriers. Legal uncertainty, state by state variability in paraphernalia laws, and the persistent risk of criminalization complicate implementation and may deter program participation. Governance questions—including who oversees the data, how it may be used, and what protections prevent misuse—are particularly critical given the vulnerabilities of the communities served and the increasingly politicized landscape surrounding harm reduction strategies. To move forward responsibly, any national drug checking registry must be grounded in data protection standards, privacy compliance, deidentification, and ethical principles that minimize risks and ensure public health benefits are achieved without exacerbating harm.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 9-A-26

Subject: In Support of a National Drug Checking Registry

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee E

Policy D-95.950, "In Support of a National Drug Checking Registry," was adopted by the House of Delegates at the 2025 Annual Meeting and directs the following:

> Our AMA will study the creation of a national drug-checking data system that would provide a mechanism whereby community-run drug-checking services may communicate their de-identified results, with legal protections, data use agreements, and user opt-in/opt-out mechanisms.

This report focuses on the value of drug checking tools and services, evidence for the use of drug checking, data protection measures, and ethical considerations.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and literature were selected from PubMed and Internet search, using the text terms "drug checking." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in community drug checking, data collection, and legal protections of public health data.

BACKGROUND

Despite decades of prohibition under the 1970 Controlled Substances Act, illicit drug use remains widespread in the United States (U.S).[1] People who use drugs (PWUD) often lack accurate information about the substances they ingest, inhale, insert and inject, increasing the likelihood of polydrug exposure and unexpected contact with potent adulterants such as fentanyl and its analogues. In this context, drug checking is a critical tool for improving safety by providing real-time insight into drug composition for PWUD, community outreach, researchers, and health care professionals.[2]

Drug checking, the use of technology to provide user insight into the contents of illicit drug products, is an overdose prevention strategy with an emerging evidence base.[3–8] There were 105,007 overdose deaths in 2023 and 80,135 in 2024, primarily from illicit drug use.[9] According to the European Union Drugs Agency, "drug-checking services…provid[e] information on the content of the samples as well as advice, and, in some cases, counselling or brief interventions."[10] Drug checking provides real-time, accurate information on street-level drug composition allowing PWUD to understand the composition of the substances they consume.

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In addition to illicit substances, drug checking services are increasingly encountering regulated pharmaceuticals that are being diverted, compounded, or sold on the illicit market, including products such as hormones and GLP-1 medications. Studies on hormones are limited and often do not reflect the U.S. context, but they have documented counterfeit semaglutide products entering the U.S. through illegal online pharmacies. One investigation found that test-purchased semaglutide products from unregulated online vendors contained 7-14 percent purity (versus advertised 99 percent), delivered 29-39 percent more semaglutide than labeled, and showed evidence of endotoxin contamination.[11] The American Diabetes Association has warned that counterfeit products have made their way into the U.S. drug supply chain through online and unregulated sources.[12] Compounded GLP-1s (primarily semaglutide and tirzepatide) have proliferated through online vendors, with 79 websites identified selling these products, though these represent unregulated pharmaceutical products rather than illicit drugs.[13] A poison center study documented a sharp increase in GLP-1 exposures, predominantly from unintentional therapeutic errors, with some patients obtaining medications through online platforms and poorly regulated compounding sources.[14] These findings highlight that drug checking contends not only with illicit substances but also misrepresented or compounded regulated drugs, reinforcing the need for adaptable testing strategies capable of handling a diverse and unpredictable drug supply.

Drug Checking Technologies

There are a wide range of analytical instruments utilized in drug checking including immunoassay test strips, reagent tests, infrared absorption spectroscopy , Raman spectroscopy, surface-enhanced Raman spectroscopy (SERS), and gas chromatography mass spectrometry (GCMS). Each technology presents a unique balance of strengths and limitations, often requiring programs to weigh accuracy, portability, cost, required expertise, and environmental constraints when choosing testing mechanisms (See Appendix 1).

Drug checking technologies vary widely in complexity, sensitivity, and practical application, offering complementary strengths for identifying substances in an increasingly unpredictable drug supply. Basic tools such as immunoassay test strips and reagent tests are inexpensive, easy to use, portable, and well-suited for high volume or low resource environments, though they are limited by risks of false positives or negatives, lack of standardization, and their inability to detect concentration levels or all drug analogues.[15] More advanced spectroscopic methods, Fourier Transform Infrared Spectroscopy (FTIR), Infrared Raman (IR), and its enhanced form SERS, provide rapid, nondestructive identification of major components through chemical "fingerprinting," but their performance varies depending on sampling conditions, fluorescence interference, and instrument sensitivity, especially for trace substances.[15] At the highest level of analytical rigor, portable GCMS delivers highly accurate, trace-level detection and remains the gold standard for confirmatory testing, though it requires technical expertise, careful calibration, and laboratory grade procedures.[15] Together, these technologies illustrate the spectrum of tools available to meet diverse drug checking needs across community, clinical, and mobile settings.

Because each technology involves tradeoffs in cost, portability, speed, and training requirements, drug checking programs benefit from access to multiple technologies. A multi-instrument approach provides clear advantages by allowing verification across methods, increasing confidence when substances are detected by more than one technique. Rapid optical tools like test strips, IR and handheld Raman are sufficient for identifying major components or confirming drug classes, particularly in high population/dense settings such as music concerts and festivals. However, these portable methods struggle when active ingredients are at very low concentrations. In these cases, confirmatory laboratory-based analysis, often using mass spectrometry, remains essential for accurate trace-level detection and quantification. Ultimately, drug checking and an understanding,

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of each technology's capabilities and constraints can deliver accurate, actionable, and timely information.[15]

Generalizability of Drug Checking Results

The hyper-variability of the unregulated drug supply necessitates a shift toward precision-based harm reduction. A Philadelphia-based program illustrated this by documenting two separate overdose clusters on the same block involving entirely different substances within a 15-minute window.[16] Rather than diminishing the value of the data, this case highlights why drug checking is an indispensable tool for real-time risk assessment. While geopolitical boundaries and historical data offer limited predictive power, drug checking fills a critical gap by providing the individualized, immediate information required to navigate a rapidly shifting supply environment.

DISCUSSION

Potential Health Care and Physician Utilization of Drug Checking Results

Drug checking has the potential to meaningfully inform health care practices by providing clinicians with timely, real-world insight into the rapidly shifting illicit and counterfeit drug supply. Because drug checking technologies can identify both major and trace components in substances, drug checking data can help clinicians better understand what their patients are likely exposed to and tailor clinical care accordingly. For physicians, access to drug checking results can improve the accuracy of overdose assessments, guide decisions about reversal and withdrawal management agents, anticipate polysubstance complications, and inform conversations about secondary prevention. These insights can also help clinicians counsel patients on adulterants that may not be apparent, especially given the rise of counterfeit and substandard regulated pharmaceuticals circulating alongside illicit drugs.

Beyond direct clinical care, drug checking can strengthen surveillance systems and bridge gaps between frontline health care, community-based programs, and public health agencies. Physicians who understand drug checking data may be better equipped to identify emerging trends, such as novel psychoactive substances or unexpected adulteration patterns, before they appear in traditional toxicology or mortality reporting, which often lags behind real-time trends. National efforts like National Drug Early Warning System (NDEWS) and state-level dashboards already demonstrate the value of integrating early warning systems to inform prevention and response strategies across health sectors.[17] As drug checking becomes more widespread, physicians may increasingly rely on these data to guide evidence-informed decision-making, advocate for safer drug supply interventions, and contribute to a more coordinated public health response.

Drug Checking Evidence and Outcomes

Drug checking programs have demonstrated measurable impacts on attitudes and intended behaviors among people who use drugs. Studies consistently show that when individuals receive unexpected or concerning test results—such as confirmation of fentanyl adulteration—they are more likely to express intentions to reduce their dose or avoid using the substance altogether. For example, a supervised injection site in Vancouver, BC reported that 36.3 percent of participants planned to reduce their drug dose after receiving concerning test results, and similar findings were observed in festival settings where unexpected results prompted users to reconsider their intended use.[18,19] However, attitude changes do not always translate into actual behavior change, highlighting the need for education and counseling to reinforce secondary harm prevention practices.[20]

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Evidence on actual drug use behavior changes is mixed but generally positive. While some participants disposed of adulterated substances after testing, many continued to use them, often with modifications such as smaller doses, slower administration, or using with others present. For instance, in San Francisco, among those who received positive fentanyl test strip (FTS) results, 26.5 percent disposed of the substance, 30.1 percent reduced their use, and 43.4 percent made no changes.[21] Other programs reported adoption of risk reduction behaviors, such as keeping naloxone nearby or injecting a test shot, particularly among individuals who were previously unaware of adulteration. For example, a drug checking program at a syringe services site in the southeastern U.S. reported that 63 percent of FTS results were positive, and individuals who received a positive result were five times more likely to change their drug use behavior compared to those with negative results.[6] Additional positive behaviors included a willingness to share information about FTS and distribute them to peers at high risk of exposure.[22] These findings suggest that drug checking can change behavior, and reduce anticipated lethality, even though complete avoidance usually does not occur.

Legality of Drug Checking

In the absence of federal laws, the legality of drug checking is governed at the state-level. A 50 state survey on the legality of drug checking equipment found that state paraphernalia laws remain a major barrier to scaling drug checking initiatives.[23] Most of these laws are modeled after a DEA framework from the late 1970s which categorize nearly all items associated with illicit drug use as "drug paraphernalia." While enforcement against drug checking equipment (DCE) is rare, these statutes create confusion and may discourage the implementation and funding of drug checking programs.[23]

A review of laws across all 50 states, the District of Columbia, and Puerto Rico between 2021 and 2024 revealed persistent structural barriers that complicate the implementation of drug checking services.[8] The review concluded "…that all forms of DCE are legal to sell, give away, and possess in 20 states. Massachusetts and Michigan allow possession and free distribution of DCE but prohibit its sale. Six states allow possession of all DCE but restrict or prohibit both free distribution and sale. Thirteen states expressly allow the possession, free distribution, and sale of DCE only for specific drugs or with certain types of testing modalities—most commonly fentanyl and fentanyl test strips—while the same activities with all other forms of DCE remains illegal. Two states restrict possession of DCE to only fentanyl test strips, while allowing distribution or sale of DCE more generally. In five states and territories (Indiana, Iowa, North Dakota, Puerto Rico, and Texas) possession, free distribution, and sale of all drug checking equipment remains arguably a crime, typically because the law both defines paraphernalia as including testing equipment and criminalizes the possession of such paraphernalia."[23] The wide variation and criminalization of DCE hinders the ability to establish a national framework for drug checking.

Laws regarding the distribution of DCE by syringe exchange programs (SSPs) are at times legally unclear. In approximately six states, SSPs are permitted to distribute DCE even when such distribution is not otherwise permitted. [23] Good Samaritan laws in 39 states provide protection from criminal action related to DCE. [23] Recently, many states have modified their laws to increase access to DCE. Between August 2021 and August 2024, 37 states modified their laws to increase access to DCE including possession and distribution.[23] However, laws vary by state. [23] For example, the laws in Georgia, Kentucky, and Tennessee are limited to devices used to detect synthetic opioids, while laws in Alabama, Arizona, Florida, Louisiana, Mississippi, Missouri, and South Dakota apply only to objects used to test for fentanyl or fentanyl analogues. Those in Hawaii, and Oklahoma apply only to FTS.[23] In many states where DCE is not clearly legal, distribution occurs through health departments and other entities (Appendix 2).[23] These findings

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underscore the need for federal and state-level action to provide legal protections for programs and people conducting services. Without such changes, efforts to establish a national drug checking data system will face significant legal and operational challenges.

Funding of Drug Checking Programs

Drug checking programs in the U.S are typically associated with universities, public health departments, and community-based organizations that often work together to publish data and dashboards regarding drugs in their communities. [24–28] Locally, community programs are either privately funded through grants or have grants with their local or state health department through federal funding sources such as Centers for Disease Control and Prevention (CDC). The current government grant funding for drug checking is through the CDC's Overdose Data to Action Local (OD2A: LOCAL) surveillance grants which, "fund jurisdictions to test drug products and/or drug paraphernalia to identify and track emerging public health threats in illicit drug markets so they can understand and respond to drug overdose outbreaks."[29] As of February 2026, 40 health departments are funded by OD2A: LOCAL program in 25 states.[30]

Opioid litigation settlement funds represent a major opportunity to support evidence-based secondary prevention strategies, including drug checking, by financing the infrastructure, workforce, laboratory capacity, and community-based services needed to detect emerging drug threats and reduce overdose deaths. As of November 2025, most states and several U.S. territories have enacted laws governing how opioid settlement funds may be used, while a smaller number rely on written policies, and others absorb the funds into their general budget without spending guidance or are overseen by established councils/committees to approve disbursements or provide recommendations.[31]

Data Protection Measures

Key components for national standards for data protection are adherence to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, safeguarding personally identifiable health information (PII), under HIPAA, the privacy rule sets limits on how protected health information may be used or disclosed, The Security Rule established technical, administrative, and physical safeguards that organizations must implement to protect electronic health information, and The Health Information Technology for Economic and Clinical Health Data Act, which expands HIPAA's privacy and security protections, enhances breach-notification standards, and increases accountability for improper handling of personal health information.[32] These national protection standards are essential for some drug checking efforts because they ensure that sensitive health related information is handled safely, reducing the risk of criminal-legal consequences or misuse of data for people who use these services.

Drug checking and health information can contain highly sensitive details, which, if disclosed, could lead to stigma, reputational harm, and barriers to employment, insurance, or housing. To mitigate these risks, strong privacy protections and data security measures are essential. De-identification is a common strategy that removes direct identifiers, but it does not fully eliminate the risk of re-identification, especially when quasi-identifiers—such as gender or ZIP code—remain in the dataset.[33] De-identified information is commonly used in public health research to prevent information from being traced back to an individual. Although the likelihood of re-identification under HIPAA's Safe Harbor standard is very low (estimated at 0.04 percent), rare attributes can increase this risk.[33] Examples of the types of public health data, vulnerable populations associated with de-identified information, and federal laws governing disclosure are available in Appendix 3 and 4.

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Drug Databases that Currently Exist

As of winter 2026, the CDC monitors drug overdoses through two primary systems: the Nonfatal Drug Overdose Surveillance and Epidemiology system, which tracks nonfatal overdoses using near–real-time syndromic emergency department data and finalized hospital discharge records, and State Unintentional Drug Overdose Reporting System, which collects detailed information on fatal overdoses from death certificates, medical examiner and coroner reports, autopsies, and toxicology results across 49 states and DC, together providing a comprehensive picture of both nonfatal and fatal overdose trends.[34,35]

Complementing these systems, the National Drug Early Warning System functions as a real-time national surveillance network that detects emerging drug threats by integrating traditional data sources with rapid signal indicators such as community reports, 911 dispatch data, wastewater analysis, darknet monitoring, and machine learning detection of new psychoactive substances, producing timely intelligence that fills critical gaps left by slower indicators like mortality and treatment data and offering a proactive framework for tracking shifts in drug availability, use patterns, and emerging risks.[17]

In some jurisdictions, useful information can be obtained from data systems covering emergency medical services; from poison centers; and from health departments that maintain records of drug "overdoses" and poisonings. These programs vary between states and within states, and specifics are beyond the scope of this report. Such relationships can enable the sharing of important and mutually helpful statistical data, but the confidentiality requirements of each service must be scrupulously respected. This focus on confidentiality is especially important for drug checking services, which depend entirely on voluntary cooperation from persons who use drugs and thus are especially reliant on their reputation for confidentiality.

Several states have developed online platforms to share drug checking data with the public and health professionals. For example, New York State provides a dedicated webpage through its Department of Health that publishes results from local drug checking programs, including information on substances detected and adulterant trends.[36] Washington State, through the University of Washington, offers a comprehensive drug checking data portal that aggregates results from community-based programs and highlights emerging substances and adulteration patterns.[37]

In addition to dashboards, there are also applications that have been created to allow drug sample collection reporting across programs. The StreetCheck app, developed by Brandeis University's Opioid Policy Research Collaborative and funded through the Massachusetts Department of Public Health, enables users to log test samples—from simple strips to advanced spectrometers—streamlining result delivery and reinforcing prevention messaging in real time.[38] However, users may face challenges without the technical familiarity needed for accurate reporting, whereas trained staff are equipped to ensure correct, complete, and reliable data entry.

There are also dashboards that show available data sent by multiple states. The University of North Carolina at Chapel Hill Street Drug Analysis Lab provides analytical chemistry services to support public health. The lab utilizes GC-MS to confirm chemical formulas of various drugs, enabling highly sensitive and definitive substance identification.[39] The lab is DEA-authorized to handle Schedule I–V controlled substances. As of January 15, 2026, the lab has analyzed 18,667 samples from 41 states, making it a key resource for monitoring drug composition and trends.[40]

The ToxIC SCANNED (Substance Checking and Analysis of New and Evolving Drug) Overdose Surveillance Program is funded by the White House Office of National Drug Control Policy to

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address critical gaps in understanding the rapidly evolving illicit drug supply.[41] ToxIC SCANNED combines advanced laboratory toxicology, emergency department data, and national drug-checking data to provide real-time insights on geographic trends, patient characteristics, and clinical outcomes.[42] Using residual urine and serum specimens from routine emergency care, the program can identify over 1,200 drugs and metabolites, offering a comprehensive view of substances contributing to medical emergencies and overdoses.[42] This initiative builds on the ToxIC Core Registry, which comprises over 50 locations throughout the U.S., with several international sites also participating. [43] The majority of active U.S. medical toxicology practices and accredited fellowship programs contribute to this registry, creating a robust network for data collection and analysis.[43] By integrating multiple data streams, from biological specimens to seized drug analyses, ToxIC SCANNED delivers a snapshot of the changing drug market.[43] However, while this registry includes some community based drug checking programs, it does not capture all of them.

The Substance Abuse and Mental Health Administration recently affirmed support for education, naloxone, drug-checking supplies, and sharps disposal kits.[44]

CURRENT AMA POLICY

Our AMA supports a comprehensive drug policy approach that includes decriminalizing secondary prevention supplies to reduce health risks associated with drug use (H-95.900, "Supporting Harm Reduction"), eliminating criminal penalties for personal drug possession, and ensuring access to evidence based prevention, treatment, and supportive services tailored to community needs (H-95.901, "Drug Policy Reform"). Additionally, our AMA advocates for removing fentanyl test strips and other drug checking tools from the legal definition of drug paraphernalia, expanding civil and criminal immunity for their possession and distribution, and increasing access to drug checking supplies as a critical strategy to prevent drug related overdose (D-95.987, "Prevention of Drug-Related Overdose").

CONCLUSION

Multiple states have shown that drug checking and dashboards are both feasible and valuable, providing timely insight into local drug markets and supporting more informed public health responses. As these systems continue to expand, the challenge is no longer whether drug checking data can be collected, but how to scale such models in ways that are ethical, safe, and responsive to the needs of diverse populations and stakeholders. Despite their promise, national drug checking efforts face substantial feasibility barriers. Legal uncertainty, state by state variability in paraphernalia laws, and the persistent risk of criminalization complicate implementation and may deter program participation. Governance questions—including who oversees the data, how it may be used, and what protections prevent misuse—are particularly critical given the vulnerabilities of the communities served and the increasingly politicized landscape surrounding harm reduction strategies.

Given these considerations, strong data protection standards must form the foundation of any drug checking data initiative. Safeguards should include strict adherence to federal and state privacy requirements and ethical principles, rigorous deidentification protocols, and protections that minimize both individual and community-level risks of reidentification and to ensure that expanding public health surveillance data does not inadvertently perpetuate stigma, inequity, or harm. With these protections in place, a national framework has the potential to support public health goals while honoring the priorities and safety of the populations most affected.

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RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA: (1) supports drug checking that provides real-world insight into the rapidly shifting drug supply, which helps reduce harm among people who use drugs, better inform clinicians, and enhance public health surveillance efforts; (2) advocates for funding and legal authorization to support drug checking services at the local, county, state, and national level; and (3) will continue to monitor ongoing drug checking efforts. (New HOD Policy)

2. That our AMA reaffirm the following HOD policies: H-95.900, "Supporting Harm Reduction,"; H-95.901, "Drug Policy Reform," and D-95.987, "Prevention of Drug-Related Overdose," (Reaffirm HOD Policy)

Fiscal Note: Minimal

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APPENDIX 1 – Comparison Chart of Drug Checking Equipment

Technology	Discrimination / Accuracy	Substances Detected	Identifies Specific Compounds?	Quantifies?	Training Needed	Cost Range (USD)	Ease of Use	Time to Results	Portability / Infrastructure	Servicing / Support	Notes
Immunoassay (test strips)	★★	Specific, but not all compounds (e.g., fentanyl, metabolites)	Yes	No	None	Low: few dollars/strip; $50–400/mo	Basic–intermediate	Seconds–minutes	Highly portable; point-of-care	Free support (some makers)	No ongoing op costs besides strips
Infrared spectroscopy (FTIR)	★★★★	Virtually any	Yes	Yes	1–2 days	$30k–$60k + licensing	Basic–intermediate	<2 minutes	Portable; vehicles	Included: updates, warranty, support	Widely used; fast results
Raman/ NIR/SERS	★★★★	Virtually any	Yes	Yes	Training needed	Midrange; licensing	Basic	5–15 minutes	Portable	Included: software, warranty	Often paired with test strips
Mass spectrometry	★★★★★	Virtually any	Yes	Yes	Trained tech required	High: $100k+; high	Intermediate–advanced	<3 min (mini)	Not portable except mini-MS	Included (varies)	Highest accuracy

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						recurring		/ 5–20 min			
Thin-layer chromatography (TLC)	★★★	Most organics; common drugs	Yes	Yes	Basic–intermediate	$200–$500; <$300/mo	Basic–intermediate	Minutes	Portable	Minimal support	Good for low-resource settings
Ultraviolet spectroscopy	★★	Drugs w/ UV-absorbing groups	Yes	No	Basic	$1k–$3k	Basic–intermediate	Minutes	Portable	Some support	Less common in harm reduction
X-ray diffraction	★★★	Crystalline solids	Yes	Yes	Advanced-expert	$15k–$60k	Intermediate–advanced	Minutes–hours	Lab-bound	Varies	Confirms crystal structure
Reagent tests	★	Broad categories	No	No	None	Very low cost	Basic	Seconds	Portable	None	High false results
Microcrystal tests	★★	Several	Yes	No	Intermediate	Low; $300–800/yr	Intermediate	Minutes	Portable	Some	Identifies certain substances

Harper J, Powell J, Pijl E. An overview of forensic drug testing methods and their suitability for harm reduction point-of-care services. *Harm Reduction Journal*. 2017;14(52). doi:10.1186/s12954-017-0179-5 [45]

Canadian Journal of Health Technologies. Drug-Checking Technologies to Detect Compositions of Unregulated Substance Samples. *Canadian Journal of Health Technologies*. 2026;6(1).[46]

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APPENDIX 2. 2024 Legal Status of Drug Checking Equipment

State	Possession of DCE generally permitted[26]	Free distribution of DCE generally permitted	Sale of DCE generally permitted	Free distribution of DCE from SSPs clearly permitted	Possession of DCE obtained from SSPs clearly permitted	Good Samaritan law covers DCE
Alabama	Fentanyl: Yes Others: No[27]	Fentanyl: Yes Others: No[28]	Fentanyl: Yes Others: No[29]	N/A[30]	N/A[31]	Yes[32]
Alaska	Yes[33]	Yes[34]	Yes[35]	Yes[36]	Yes[37]	N/A
Arizona	Fentanyl: Yes Others: No[38]	Fentanyl: Yes Others: No[39]	Fentanyl: Yes Others: No[40]	Fentanyl: Yes Others: No[41]	Fentanyl: Yes Others: No[42]	Yes[43]
Arkansas	Fentanyl test strips: Yes Others: No[44]	Yes[45]	Yes[46]	Yes[47]	Fentanyl test strips: Yes Others: No [48]	No[49]
California	Yes[50]	Fentanyl and analogs, ketamine, and gamma hydroxybutyric acid: Yes Others: No[51]	Fentanyl and analogs, ketamine, and gamma hydroxybutyric acid: Yes Others: No[52]	Yes[53]	Yes[54]	Yes[55]
Colorado	Yes[56]	Yes[57]	Yes[58]	Yes[59]	Yes[60]	Yes[61]
Connecticut	Yes[62]	Yes[63]	Yes[64]	Yes[65]	Yes[66]	Yes[67]
Delaware	Fentanyl and xylazine test strips: Yes Others: No[68]	Fentanyl and xylazine test strips: Yes Others: No[69]	Fentanyl and xylazine test strips: Yes Others: No[70]	Fentanyl and xylazine test strips: Yes Others: No[71]	Fentanyl and xylazine test strips: Yes Others: No[72]	Yes[73]

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Florida	Fentanyl: Yes Others: No[74]	Fentanyl: Yes Others: No[75]	Fentanyl: Yes Others: No[76]	Fentanyl: Yes Others: No[77]	Fentanyl: Yes Others: No[78]	Yes[79]
Georgia	Synthetic Opioids: Yes Others: No[80]	Synthetic Opioids: Yes Others: No[81]	Synthetic Opioids: Yes Others: No[82]	Synthetic Opioids: Yes Others: No[83]	Synthetic Opioids: Yes Others: No[84]	Yes[85]
Hawaii	Fentanyl test strips: Yes Others: No[86]	Fentanyl test strips: Yes Others: No[87]	Fentanyl test strips: Yes Others: No[88]	Fentanyl strips: Yes Others: No[89]	Fentanyl strips: Yes Others: No[90]	Yes[91]
Idaho	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[92]	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[93]	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[94]	N/A[95]	N/A[96]	Yes[97]
Illinois	Yes[98]	Yes[99]	Yes[100]	Yes[101]	Yes[102]	Yes[103]
Indiana	No[104]	No[105]	No[106]	Yes[107]	No[108]	Yes[109]
Iowa	No[110]	No[111]	No[112]	N/A[113]	N/A[114]	Yes[115]
Kansas	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[116]	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[117]	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[118]	N/A[119]	N/A[120]	No[121]
Kentucky	Synthetic Opioids: Yes Others: No[122]	Synthetic Opioids: Yes Others: No[123]	Synthetic Opioids: Yes Others: No[124]	Yes[125]	Synthetic Opioids: Yes Others: No[126]	Yes[127]
Louisiana	Fentanyl: Yes Others: No[128]	Fentanyl: Yes Others: No [129]	Fentanyl: Yes Others: No[130]	Yes[131]	Yes[132]	Yes[133]

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State	Possession of DCE generally permitted[26]	Free distribution of DCE generally permitted	Sale of DCE generally permitted	Free distribution of DCE from SSPs clearly permitted	Possession of DCE obtained from SSPs clearly permitted	Good Samaritan law covers DCE
Maine	Yes[134]	Yes[135]	Yes[136]	Yes[137]	Yes[138]	Yes[139]
Maryland	Yes[140]	Yes[141]	Yes[142]	Yes[143]	Yes[144]	Yes[145]
Massachusetts	Yes[146]	Yes[147]	No[148]	Yes[149]	Yes[150]	N/A[151]
Michigan	Yes[152]	Yes[153]	No[154]	Yes[155]	Yes[156]	N/A[157]
Minnesota	Yes[158]	Yes[159]	Yes[160]	Yes[161]	Yes[162]	Yes[163]
Mississippi	Fentanyl: Yes Others: No[164]	Fentanyl: Yes Others: No[165]	Fentanyl: Yes Others: No[166]	N/A[167]	N/A[168]	Yes[169]
Missouri	Fentanyl and fentanyl analogs: Yes[170] Others: No	Fentanyl and fentanyl analogs: Yes[171] Others: No	Fentanyl and fentanyl analogs: Yes[172] Others: No	N/A[173]	N/A[174]	Yes[175]
Montana	Yes[176]	No[177]	No[178]	Yes[179]	No[180]	Yes[181]
Nebraska	Yes[182]	Yes[183]	Yes[184]	N/A[185]	N/A[186]	Yes[187]
Nevada	Yes[188]	Yes[189]	Yes[190]	Yes[191]	Yes[192]	Yes[193]
New Hampshire	Yes[194]	Fentanyl and xylazine: Yes Others: No[195]	Fentanyl and xylazine: Yes Others: No[196]	Fentanyl and xylazine: Yes Others: No[197]	Yes[198]	N/A[199]
New Jersey	Yes[200]	Yes[201]	Yes[202]	Yes[203]	Yes[204]	Yes[205]
New Mexico	Yes[206]	No[207]	No[208]	Yes[209]	Yes[210]	Yes[211]
New York	Yes[212]	Yes[213]	Yes[214]	Yes[215]	Yes[216]	Yes[217]
North Carolina	Yes[218]	No[219]	No[220]	Yes[221]	Yes[222]	Yes[223]

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North Dakota	No[224]	No[225]	No[226]	No[227]	No[228]	Yes[229]
Ohio	Fentanyl test strips: Yes Others: No[230]	Yes[231]	No[232]	Yes[233]	Fentanyl strips: Yes (within 1,000 feet of SSP only) Others: No[234]	Yes[235]
Oklahoma	Fentanyl test strips: Yes Others: No[236]	Fentanyl test strips: Yes Others: No[237]	Fentanyl test strips: Yes Others: No[238]	Yes[239]	Fentanyl strips: Yes Others: No[240]	Yes[241]
Oregon	Yes[242]	Yes[243]	Yes[244]	Yes[245]	Yes[246]	Yes[247]
Pennsylvania	Yes[248]	Yes[249]	Yes[250]	N/A[251]	N/A[252]	Yes[253]
Puerto Rico	No[254]	No[255]	No[256]	Yes[257]	Yes[258]	No[259]
Rhode Island	Yes[260]	Yes[261]	Yes[262]	Yes[263]	Yes[264]	N/A[265]
South Carolina	Yes[266]	Yes[267]	Yes[268]	Yes[269]	Yes[270]	Yes[271]
South Dakota	Fentanyl: Yes Others: No[272]	Fentanyl: Yes Others: No[273]	Fentanyl: Yes Others: No[274]	N/A[275]	N/A[276]	No[277]
Tennessee	Synthetic opioid: Yes Others: No[278]	Synthetic opioid: Yes Others: No[279]	Synthetic opioid: Yes Others: No[280]	Synthetic opioid: Yes Others: No[281]	Synthetic opioid: Yes Others: No[282]	Yes[283]
Texas	No[284]	No[285]	No[286]	N/A[287]	N/A[288]	Yes[289]
Utah	Yes[290]	Yes[291]	Yes[292]	Yes[293]	Yes[294]	Yes[295]
Vermont	Yes[296]	Yes[297]	Yes[298]	Yes[299]	Yes[300]	N/A[301]
Virginia	Yes[302]	Yes[303]	Fentanyl: Yes Others: No[304]	Yes[305]	Yes[306]	Yes[307]
Washington D.C.	Yes[308]	No[309]	No[310]	Yes[311]	Yes[312]	Yes[313]
Washington	Yes[314]	Yes[315]	Yes[316]	Yes[317]	Yes[318]	N/A[319]
West Virginia	Yes[320]	Yes[321]	Yes (with some exceptions)[322]	Yes[323]	Yes[324]	N/A[325]
Wisconsin	Fentanyl and Xylazine: Yes Others: No[326]	Fentanyl and Xylazine: Yes Others: No[327]	Fentanyl and Xylazine: Yes Others: No[328]	Yes[329]	Yes[330]	Yes[331]
Wyoming	Yes[332]	Yes[333]	Yes[334]	N/A[335]	N/A[336]	N/A[337]

Dennis A, Davis C. Legality of Drug Checking Equipment in the United States. The Network for Public Health Law; 2024. Accessed July 16, 2025. https://www.networkforphl.org/resources/legality-of-drug-checking-equipment-in-the-united-states/

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APPENDIX 3. Vulnerable Populations Associated with Different Types of Public Health Data

Centers for Disease Control and Prevention. Legal and Ethical Framework to Use Centers for Disease Control and Prevention Data for Patient-Centered Outcomes Research.

Degrees of identifiability	Explanation of terms	Examples	Possible vulnerable populations	CDC safeguards in addition to technical safeguards
Data with direct identifiers	Information that relates specifically to an individual. The inclusion of a name, Social Security number, or phone number, makes data identifiable.	US Zika Pregnancy Registry[79]	Pregnant women whose fetuses would be at high risk for complications	No access to individual-level data. Information is released to the public in an aggregate form.
Linkable or coded data	Data that is not identifiable, but can be linked to a named person with the use of a secure code.	HIV case reports[80]	Patients infected with HIV	Data is sent from the state health department to CDC using a Soundex code.
Data with indirect identifiers	Information that can be combined with other information to identify specific individuals. Information about location, race, and sex can identify an individual.	National ART Surveillance System (NASS)[81]	Egg donors, surrogate mothers, and children	Only onsite access allowed with a member of the ART team.
De-identified data	Direct and known indirect identifiers in any information are removed or obscured to minimize the risk of unintended disclosure of the identity of individuals.	National Program of Cancer Registry (NPCR) Cancer Surveillance System[82]	Individuals residing in areas with high incidence of certain cancers	Most of the de-identified datasets are publicly available.
Anonymized data	Direct and indirect identifiers have been irreversibly removed or altered so that re-identification is impossible.	NHANES Genetic Data Repository[83]	Patients belonging to minority ethnic groups	Anonymized data is available with a data use agreement.

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APPENDIX 4. Federal Laws Governing Exposure of Health Data

Centers for Disease Control and Prevention. Legal and Ethical Framework to Use Centers for Disease Control and Prevention Data for Patient-Centered Outcomes Research.

Law	Provision(s) that allow disclosure of de-identified information	Criteria or standard for determining whether information is identifiable
Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, implemented by the HIPAA Privacy Rule, 45 CFR Part 160 and Part 164.	The HIPAA Privacy Rule applies to protected health information (PHI). The Privacy Rule does not apply to health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. 45 CFR § 160.103, 45 §164.500.	Information may be de-identified by removing 18 identifiers specified in the Rule, provided that the covered entity does not have actual knowledge that the remaining information can be used alone or in combination with other reasonably available information to identify a subject (safe harbor de-identification). These identifiers include personal identifiers (such as name, address, telephone number, birth date, Social Security number) and non-personal identifiers (such as geographic information smaller than a state and dates directly associated with an individual). Alternatively, a covered entity may rely on a determination by a properly qualified statistician using accepted analytic techniques who determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information (statistical de-identification). 45 CFR § 164.514.
Protection of Human Research Subjects (Common Rule), 45 CFR part 46, subpart A.	The Common Rule applies when an investigator conducting research **obtains** identifiable "private information" of a living individual (human subject) for use, study, or analysis. Private information must be **"individually identifiable"** for the Common Rule to apply. 45 CFR § 46.102(f).	Private information is individually identifiable when the identity of the subject is or may readily be ascertained by the investigator or associated with the information. 45 CFR § 46.102(f). Note: In its application of the law, the Office for Human Research Protections (OHRP) considers private information or specimens not to be individually identifiable when they cannot be linked to specific individuals by the investigator either directly or indirectly through coding systems. Examples of identifiers would include names, Social Security numbers, medical record numbers, or pathology accession numbers, or any other "code" that permits specimens or data to be linked to individually identifiable living individuals and perhaps also to associated medical information. https://humansubjects.nih.gov/from-applicants https://www.hhs.gov/ohrp/regulations-and-policy/guidance/research-involving-coded-private-information/index.html
Federal Privacy Act 5 U.S.C. § 552a.	The Federal Privacy Act establishes a code of fair information practices that governs the collection, maintenance, use, and dissemination of information about individuals that is maintained in systems of records by federal agencies. The Act protects a "record" of a U.S. citizen or alien lawfully admitted for permanent residence. A "record" includes any item, collection, or grouping of information about an individual that is maintained by a federal agency, including, but not limited to, his education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph. 5 U.S.C. § 552a(a)(4).	The law does not define or describe de-identification directly, but suggests that a record is de-identified by removing all "identifying particulars." 5 U.S.C. § 552a(a)(4).
Federal Assurance of Confidentiality, Section 308(d) of the Public Health Service Act, 42 U.S.C. § 242m.	This law prohibits use, release, and publication of information, if an establishment or person supplying the information or described in it is identifiable. Applies to information obtained in the course of health statistical, epidemiological, or other activities obtained in the course of certain activities undertaken or supported under the Public Health Service Act.	The law does not define or describe de-identification directly.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-26)

Introduced by: Academic Physicians Section

Subject: Preregistration in Medical Research

Referred to: Reference Committee E

Whereas, the scientific method relies on the clear distinction between hypothesis generation (postdiction) and hypothesis testing (prediction) to maintain the credibility of research findings[1-3]; and

Whereas, current practices in medical research often fail to adequately differentiate these processes, leading to overconfidence in findings and the increased likelihood of irreproducible results due to hindsight bias and selective reporting[2-5]; and

Whereas, preregistration is a proven methodology that requires researchers to define and publicly document their research questions, study designs, and analysis plans before data collection or analysis begins, which helps clarify the distinction between exploratory and confirmatory research[1, 2-9]; and

Whereas, evidence suggests that preregistration improves the reproducibility, transparency, and credibility of research findings by reducing biases, clarifying the distinction between exploratory and confirmatory analyses, and mitigating the misuse of statistical inference methods such as null hypothesis significance testing[1, 2, 6, 7, 9]; and

Whereas, numerous platforms and frameworks now exist to facilitate preregistration across disciplines, including clinical trials, and its adoption has been associated with improved research practices, including increased detection of reporting biases and enhanced public trust in scientific findings[2, 6, 8]; and

Whereas, AMA policy H-460.941 supports preregistration; therefore be it

RESOLVED, that our American Medical Association amend policy H-460.941 by addition and deletion to read as follows:

Our AMA will:

(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;

(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;

(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;

(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;

(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;

(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and

~~(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.~~

(7) recognize the importance of preregistration as a cornerstone of rigorous and reproducible biomedical research:

(8) collaborate with relevant stakeholders to advocate for the integration of preregistration into medical research protocols, emphasizing its use for clinical trials, observational studies, and other research contexts;

(9) collaborate with relevant stakeholders to support efforts to provide training and resources for medical researchers to implement preregistration effectively, including access to standardized registries and education on preregistration practice; and

(10) collaborate with relevant stakeholders in the medical and scientific community to promote policies and incentives that align preregistration with the goals of career advancement, funding acquisition, and publication, fostering a culture of transparency and accountability in medical research.

(Modify Current HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 3/17/26

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RELEVANT AMA POLICY

Science and Biomedical Research H-460.941

Opportunities, Challenges and Health System Reform
Our AMA will:
(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;
(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;
(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;
(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;
(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;
(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and
(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research. [CSA Rep. 8, A-94; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 901, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-26)

Introduced by: Washington

Subject: Support for Rapid Methadone Inpatient Stabilization and Linkage to Care

Referred to: Reference Committee E

Whereas, Opioid Use Disorder (OUD) impacts 2.5 million adults a year, and in 2021 only 22% of adults with OUD received medications to treat OUD[1]; and

Whereas, emergency department visits and hospitalizations for complications from untreated OUD are teachable moments and opportunities to initiate medications for opioid use disorder; and

Whereas, methadone is an effective treatment for withdrawal management and stabilization for OUD in the fentanyl era[2]; and

Whereas, the Washington state legislature approved a 2024 budget proviso to devote $2,000,000 of the opioid abatement settlement account to implement a rapid methadone inpatient stabilization pilot program designed by the Washington Society of Addiction Medicine (WSAM); and

Whereas, WSAM worked with the Washington State Health Care Authority to create a policy for rapid methadone inpatient stabilization for treatment of OUD in pregnant patients that includes higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing of naloxone and 72 hours of methadone; and

Whereas, this innovative treatment strategy has demonstrated effectiveness with initial data[3] showing 100% methadone stabilization, 86% attending an opioid treatment program intake visit, and 57% remaining on methadone at 30 days post-discharge; therefore be it

RESOLVED, that our American Medical Association will endorse and advocate for implementation of a rapid methadone inpatient stabilization pathway for treatment of Opioid Use Disorder in pregnant patients, with higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing an appropriate amount of naloxone and methadone. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 3/13/26

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RELEVANT AMA POLICY

H-420.950 Substance Use Disorders During Pregnancy

1. Our American Medical Association supports brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions.
2. Our AMA acknowledges the health benefits of identifying substance use during pregnancy and opposes any efforts, including mandatory reporting laws, that imply a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse or neglect.
3. Our AMA supports legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy.
4. Our AMA opposes the filing of a child protective services report or the removal of infants from their parent(s) solely based on a prenatal drug screen and/or biological test(s) for substance use without appropriate evaluation.
5. Our AMA advocates for appropriate medical evaluation prior to the removal of a child, which takes into account:
   a. the desire to preserve the individual's family structure;
   b. the patient's treatment status; and
   c. current impairment status when substance use is suspected or confirmed.
6. Our AMA advocates that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, diagnosis of a substance use disorder, or use of evidence-based treatments for substance use disorder.
7. Our AMA encourages ongoing research on the benefits and risks of universal screening for substance use during pregnancy including the impact of mandatory reporting laws, evaluation of patient outcomes, effectiveness across different age groups, optimal screening intervals, equity considerations, and efficacy of different screening tools.
8. Our AMA supports the development and dissemination of physician education and training on federal and state laws governing mandatory notification and reporting of substance use during pregnancy, and the benefits and consequences of screening implementation in health care settings on a state-by-state basis.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-26)

Introduced by: Pennsylvania

Subject: Expansion of Psychedelic Assisted Therapy (PAT)

Referred to: Reference Committee E

Whereas, other psychedelic and/or psychotherapeutic compounds with novel uses, such as MDMA, have received Breakthrough Therapy designation from the U.S. Food and Drug Administration (FDA); and

Whereas, other psychedelic and/or psychotherapeutic compounds with novel uses such as ketamine are already being prescribed for various mood disorders, but often with little oversight or widely-recognized standard of care; and

Whereas, the American Medical Association has a vested and explicit interest in the safe, evidence-based practice of medicine; and therefore be it

RESOLVED, that our American Medical Association reaffirm policies H-120.917 and H-100.943. (Reaffirm HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-26)

Introduced by: Delaware

Subject: Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence

Referred to: Reference Committee E

Whereas, rubber gloves have been in use since Dr. William Halsted from The Johns Hopkins Hospital had the Goodyear Rubber Products company produce thin gloves to protect the nursing staff from harsh chemicals and disinfectants in the late nineteenth century;[1] and

Whereas, rubber glove development evolved over time leading to gloves that are sturdy and protective for many health care workers and others involved in patient care in various inpatient and outpatient settings; and

Whereas, the Buy American Act (BAA) requires Federal agencies to prioritize the production and purchase of domestic, U.S. manufactured goods and materials for public use in the United States with the materials used in manufacturing present in the U.S. in sufficient and reasonably available commercial quantities of a satisfactory quality, creating a preference for purchasing and manufacturing domestically and restricting the purchase of supplies that are not domestic end products;[2] and

Whereas, the Buy American Act (BAA) provisions can be waived if the procuring agency determines the act to be inconsistent with the public interest or the cost of acquiring the domestic product is unreasonable; and

Whereas, the HIV/AIDS epidemic, the Asian financial crisis, and more recently the COVID-19 pandemic fueled a worldwide demand for rubber gloves in a variety of health care settings;[3] and

Whereas, demand for rubber gloves led to major rubber glove producers in Malaysia and Thailand, such as Top Glove and WRP, to employ children as young as eight years old and exploited migrants from Nepal, India, Myanmar, and Bangladesh by having them work in unsafe factories, work up to 160 hours of overtime, withhold salaries for months, utilize high recruitment fees that led to debt bondage, and confiscated passports;[4-15] and

Whereas, on July 15, 2020, United States Customs and Border Protection (CBP) issued a Withhold Release Order (WRO) that banned Top Glove-produced rubber gloves from import into the United States because the gloves were made by forced labor and under the WRO, the CBP seized several shipments of disposable gloves that originated in Malaysia;[16, 17] and

Whereas, on September 9, 2021, the Customs and Border Protection (CBP) issued a modification[18,19] of its forced labor findings on Top Glove, allowing imports to resume, with the CBP affirming that Top Glove had issued “more than $30 million in remediation payments to workers and [is] improving labor and living conditions at the company’s facilities”; and

Whereas, Smart Glove, a collective group of Malaysian glove makers, faced a U.S. ban in 2021 for debt bondage and other labor allegations;[20] and

Whereas, unfair labor practices and overall safety persist in major rubber glove companies in Malaysia, in particular;[21,22] and

Whereas, on January 26, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an Advance Notice of Proposed Rulemaking seeking public input on strengthening the domestic supply chain for personal protective equipment (PPE) and essential medicines, exploring ways to reduce reliance on foreign-made medical supplies and enhance the nation's readiness for future emergencies while supporting American workers and manufacturers and also considering a "Secure American Medical Supplies" friendly designation earned by hospitals that demonstrate a commitment to domestic procurement;[23] and

Whereas, the Medical Society of Delaware has informed its federal Congressional Delegation requesting emphasis of the need for reliance on U..S. companies for more domestic rubber glove production than what is now the case and as prioritized by the Buy American Act to purchase domestic, U.S. manufactured goods and materials for public use;[24] now therefore be it

RESOLVED, that our American Medical Association advocate with the appropriate Federal agencies to prioritize production and procurement of domestically manufactured rubber gloves and their component materials consistent with the Buy American Act (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage health care systems, physicians and other health care professionals, and affiliated entities to source rubber gloves from U.S. manufacturers whenever feasible, with preference for products whose raw materials originate within the domestic supply chain (New HOD Policy); and be it further

RESOLVED, that our AMA promote rigorous supply chain transparency by urging federal regulators and relevant authorities to strengthen import enforcement, enhance due-diligence requirements, and conduct independent audits to ensure that imported rubber gloves meet appropriate ethical labor standards. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

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RELEVANT AMA POLICY

H-440.810 Availability of Personal Protective Equipment (PPE)

(1) Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
(2) Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
(3) Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
(4) Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
(5) Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
(6) Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
(7) Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

[Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-26)

Introduced by: New York

Subject: Avoiding misuse of artificial intelligence (AI) in clinical practice

Referred to: Reference Committee E

Whereas, artificial intelligence(AI) is finding its way into the clinical practice of medicine; and Whereas, physicians, nurse, practitioners, physicians, assistance, CRNA's and other healthcare professionals have begun using AI to generate notes in an effort to become more efficient and save time in the care of patients; and

Whereas, physicians and other healthcare professionals become medically and legally responsible for the care of their own patients and the patients receiving care from non-physician professionals for whom they may be collaborating for or supervising; and

Whereas, the review of all documentation in the patient's medical record, whether entered by the physician or other healthcare professional, a scribe or AI is owned by the author who signed that documentation; and

Whereas, the possibility that there could be an error in the medical record specifically related to documentation generated by AI, that could become a medical or medical legal issue; therefore be it

RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document (New HOD Policy); and be it further

RESOLVED, that any physician or healthcare professional, who chooses to use Artificial Intelligence (AI) in the creation of the medical record, understands that the accuracy of that record is completely the responsibility of that author. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-26)

Introduced by: New York

Subject: Access To Gender Affirming Healthcare Including Clinical Trials

Referred to: Reference Committee E

Whereas, gender dysphoria in children and adolescents is a complex clinical condition that requires careful, individualized, and multidisciplinary evaluation involving medical, surgical, and mental health expertise; and

Whereas, the current scientific evidence regarding gender-affirming hormonal therapies and surgical procedures in minors remains limited and evolving, with a lack of robust, long-term data on physical health outcomes, mental health outcomes, fertility, sexual function, and regret; and

Whereas, existing studies related to gender-affirming surgery in pediatric populations are largely observational, involve small cohorts, and have relatively short follow-up periods, further limiting the ability to draw definitive conclusions regarding long-term safety and effectiveness; and

Whereas, more research is needed in order to properly address gender dysphoria in minors; therefore be it

RESOLVED, that our American Medical Association affirms that Gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians (New HOD Policy); and be it further

RESOLVED, that our AMA calls for continued research including clinical trials regarding the evidence of the effectiveness of puberty blockers (GnRH analogs) on transgender and non-binary youth (New HOD Policy); and be it further

RESOLVED, that our AMA calls for the restoration of previously allocated federal, state and institutional funding for pediatric gender clinics, puberty blocker research protocols, and supportive mental health services. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-26)

Introduced by: American College of Lifestyle Medicine, Underrepresented in Medicine Advocacy Section

Subject: Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications

Referred to: Reference Committee E

Whereas, obesity is a chronic disease, requiring long-standing therapy, that has historically been difficult to ameliorate for long-term results other than with the modality of bariatric surgery; and

Whereas, obesity represents a worldwide pandemic with multiple, adverse sequelae, including type 2 diabetes and cardiovascular diseases; and

Whereas, over 74% of the U.S. population is either overweight or obese; and

Whereas, worldwide, 2.1 billion individuals suffer from obesity and these numbers are projected to grow to over 3.1 billion individuals by 2050; and

Whereas, in recent years, glucagon-like peptide-1 (GLP-1) receptor agonists were synthesized as a class of medication, mimicking a neural hormone (incretin) of the small intestine that regulates blood sugar, decreases appetite and promotes satiety as well as additional benefits that include cardiovascular and renal protections; and

Whereas, the GLP-1 receptor agonists trigger insulin release from the pancreas, block glucagon secretion which, in turn, blocks added glucose into the blood, slows emptying of the stomach, increases satiety, lowers blood pressure, improves lipid disorders, improves fatty liver disease, delays progression of diabetic related nephropathies and helps reduce cravings for toxic substances; and

Whereas, the GLP-1 receptor agonists have been prescribed specifically for the management of obesity and Type 2 Diabetes because they help lower blood sugar levels and promote satiety as a means of weight loss; and

Whereas, the most effective management of both obesity and Type 2 Diabetes requires the combination of healthy lifestyle choices, diet modifications. behavioral modifications and select medications hinge on how one modifies their lifestyle in the areas of exercise, diet, restorative rest, stress management, control of toxic exposures and supportive social interaction; and

Whereas, the GLP-1 receptor agonists can serve as a metabolic catalyst, helping regulate appetite, alleviate joint pain, and enhance mobility, which in turn supports the adoption of sustainable lifestyle changes; and

Whereas, optimizing lifestyle choices, achieved through durable behavioral modification, serves as a foundational component of whole person clinical care; informed by shared goal setting and key lifestyle domains such as nutrition, physical activity, restorative sleep, healthy stress management strategies, avoidance of harmful exposures, and prioritizing social relationships; and

Whereas, the American College of Lifestyle Medicine, The Obesity Society, The Obesity Medicine Association and the American Society for Nutrition recently issued its joint position statement on the use of GLP-1 receptor agonists for obesity indicating that such modalities be administered in conjunction with planned and monitored adaptations to the forementioned six lifestyle pillars, ergo - all clinicians prescribing GLP-1(RA)s for obesity management should establish a thoughtful plan of care that includes thorough nutritional and lifestyle counseling before, during and after the weight reduction period; and

Whereas, the World Health Organization recently issued its Guidelines on the use of GLP-1 receptor agonists to treat obesity, placing obesity in the same category as hypertension and diabetes, and recommending that (i) GLP-1 receptor agonist therapies be used by non-pregnant adults for long-term obesity treatment and improving metabolic health outcomes and (ii) that intensive behavioral interventions for lifestyle modifications be offered in conjunction with prescribed GLP-1 receptor agonist medications; and

Whereas, access to structured, evidence-based lifestyle intervention programs and trained inter-professional care teams varies significantly by geography, insurance coverage, and socioeconomic status, creating the potential for health disparities among patients prescribed GLP-1 receptor agonist therapy; therefore be it

RESOLVED, that our American Medical Association support, publicize, and advocate for the concomitant use of evidence-based, structured lifestyle and behavioral intervention programs, delivered with ongoing clinician and care-team support, in conjunction with the prescribed use of glucagon-like peptide-1 receptor agonists for obesity and other related, preventable disease states and illnesses (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize and address potential health disparities associated with recommendations for structured lifestyle intervention programs accompanying glucagon-like peptide-1 receptor agonist’s therapy, and advocate for equitable access to evidence-based, clinician-supported lifestyle interventions across diverse care settings, including community-based, digital, hybrid, and safety-net models of care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist’s therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

D-100.960 Creating a Registry of Potential Side Effects of GIP and GLP-1 Medications
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists' side effects, as well as potential impacts on pregnancy. [Res. 516, A-25]

H-150.953 Obesity As a Major Public Health Problem
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:
- the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
- the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
- effective interventions to prevent obesity in children and adults; and
- 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]

H-150.944 Combatting Obesity and Health
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists side effects, as well as potential impacts on pregnancy. [Res. 413, A-07 Reaffirmation A-12 Reaffirmation A-13 Modified: CSAPH Rep. 03, A-17]

H-440.842 Recognition of Obesity as a Disease
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists side effects, as well as potential impacts on pregnancy.[Res. 420, A-13 Reaffirmed: CSAPH Rep. 08, A-23]

H-440.801 Advocacy Against Obesity-Related Bias By Insurance Providers
A. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
- Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
- Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
- Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
- Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
- Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
- 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.

B. 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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-26)

Introduced by: American College of Lifestyle Medicine

Subject: Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services

Referred to: Reference Committee E

Whereas, the accurate and precise assessment of the gut microbiome has significant utility in the determination of gastrointestinal health and related at-risk prognoses of other bodily functions and conditions; and

Whereas, consumer interest in personal health has led to the development of, increasingly accessible, direct-to-consumer (DTC) gut microbiome testing services with varied analytical and clinical validities and consumer safety; and

Whereas, the quality, reliability and reproducibility of such testing services, prominently featured by media outlets, vary from more strictly regulated medical devices to more minimally regulated imprecise health and wellness products; and

Whereas, there are currently no regulatory-approved, DTC gut microbiome diagnostic tests in the U.S.; and

Whereas, such tests cannot diagnose a specific disease state; and

Whereas, our scientific knowledge corroborating the gut microbiome's relationship between structure and function is so limited that the French Society of Microbiology has advised against premature microbiome testing given the uncertainty of what is a "healthy" microbiome; and

Whereas, many of these DTC companies have extended their services beyond gut microbiome profiling to include: (i) microbe classifications as pathogenic or beneficial, (ii) comparing consumer microbiome profile to random comparative populations, (iii) postulating indices for gut microbiome health; (iv) advertising recommendations for lifestyle changes, dietary changes and/or adding dietary supplements sold by the same company (e.g., probiotics); and

Whereas, these DTC gut microbiome testing services have brought about a technological shift from methodic and standardized protocols with end-to end diagnostic testing (traditionally confined to clinical settings and trained medical professionals) to DTC at-home tests that do not undergo the same rigorous oversight per the analytical validation of traditional medical diagnostic tests that assure clinicians, patients and regulators of the reliability and actionability of reproducible test results; and

Whereas, a recent, double-blind-type study was carried out employing the services of seven commercial, DTC gut microbiome testing companies - with each company analyzing three identical, homogenous and stable gut products for a total of 21 identical samples — provided anonymously by the National Institute of Standards and Technology (NIST)— with the

surreptitious intent of assessing the precision and reproducibility of gut microbiome measurements within and across the seven companies; and

Whereas, the seven microbiome testing companies were unaware of this ongoing assessment until after all the samples had been processed and final reports received by the NIST; and

Whereas, uncontrolled variables, providing opportunity for the introduction of random bias, in the samples collection and microbiome sequencing methodologies between the seven companies included: (i) considerable variability in consumer protocols for sample collection, storage, stable temperature and shipping methods, (ii) variability in laboratory protocols for nucleic acid extraction, (iii) variabilities in sequencing technology and (iv) variabilities in bioinformatic analyses; and

Whereas, the common failing of poor comparability in the seven sets of results was methodologic variability, given the use of 21 identical homogenous samples voided the introduction of confounding factors such as biologic and composition heterogeneity, otherwise found in non-identical samples; and

Whereas, methodologic variability is the antithesis of reproducibility in scientific validation and may be extrapolated to align with an assumed, inconsistent precision of the samples' processing workflows; and

Whereas, the transparency, reliability and validity of the findings of these DTC gut microbiome testing services are paramount and critical in order for consumers to accurately prognosticate informed decisions regarding their health status and health care, rather than potentially risking unwarranted or unsafe lifestyle and healthcare decisions; and

Whereas, the findings of the seven testing services are returned to the consumer, most commonly, in the absence of clinical validity, i.e., validated diagnostic evidence, and instead rely upon inferred or correlative versus causative data; and

Whereas, the varied analytical conduct of the seven and similar kinds of testing companies would best be served and balanced by health industry and clinical users developing guidelines via a consensus document or minimum requirements to support test validity and consumer and clinician confidence; therefore be it

RESOLVED, that our American Medical Association develop policy that specifically addresses concerns about the design, use and oversight of commercial gut microbiome testing methods with regards to quality, reliability and reproducibility of results and assessments provided to lay consumers, upon which such consumers prognosticate informed decisions regarding their health status and subsequent health care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for review and graded recommendation by the United States Preventive Services Task Force on the use of Direct-to-Consumer Gut Microbiome Testing Services with regard to quality, reliability, reproducibility and validity (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Consumer Protection Agency to establish transparent safe guards and evidence-based, scientific oversight of Direct-to-Consumer Gut Microbiome Testing Services for lay and professional clinical use. (Directive to Take Action)

Fiscal Note: (Assigned by HOD)

Received: 4/15/26

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RELEVANT AMA POLICY

H-480.941 Direct-to-Consumer Laboratory Testing
1. Our American Medical Association will advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies.
2. Our AMA will encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.[Res. 526, A-18 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: CSAPH Rep. 03, A-2]

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing
Our American Medical Association recommends that genetic testing be carried out under the personal supervision of a qualified health care professional.
1. Our AMA encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information.
2. Our AMA will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test.
3. Our AMA encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information;
4. Our AMA will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms. [Res. 502, A-04 Modified: BOT Rep. 7, A-08 Reaffirmed: CSAPH Rep. 4, A-10 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17 Reaffirmed: BOT Rep. 12, I-21]

9.6.8 Direct-to-Consumer Diagnostic Imaging Tests
Diagnostic imaging tests are sometimes marketed directly to consumers before they have been scientifically validated. This can help consumers prevent disease and promote health, but may also expose patients to risk without benefit, create conflicts of interests for physicians, and be abused for profits.
Individually, physicians who offer diagnostic imaging services that have not been scientifically validated and for which a patient has not been referred by another physician have an ethical obligation to:
(a) Perform a requested diagnostic imaging test only when, in the physician's judgment, the possible benefits of the service outweigh its risks.
(b) Recognizing that in agreeing to perform diagnostic imaging on request, the physician:
(i) establishes a patient-physician relationship, with all the ethical and professional obligations such relationship entails;
(ii) assumes responsibility for relevant clinical evaluation, including pre- and post-test counseling about the test, its results, and indicated follow-up. Physicians may choose to refer the patient for post-test

counseling to an appropriate physician who accepts the patient.
(c) Obtain the patient's informed consent. In addition to the usual elements of informed consent, the physician should disclose:
(i) that the diagnostic imaging test has not been validated scientifically;
(ii) the inaccuracies inherent in the proposed test;
(iii) the possibility of inconclusive results;
(iv) the likelihood of false positive and false negative results;
(v) circumstances that may require further assessments and additional cost.
(d) Ensure that the patient's interests are primary and place patient welfare above physician interests when the physician has a financial interest in the imaging facility.
(e) Ensure that any advertisements for the services are truthful and not misleading or deceptive, in keeping with ethics guidance and applicable law.
Collectively, physicians should:
(f) Advocate for the conduct of appropriate trials aimed at determining the predictive power of diagnostic imaging tests and their sensitivity and specificity for target populations.
(g) Develop suitable guidelines for specific diagnostic imaging tests when adequate scientific data become available. [Issued: 2016]

H-460.908 Genomic-Based Personalized Medicine
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.[CSAPH Rep. 4, A-10 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-26)

Introduced by: LGBTQ+ Section

Subject: Preserving Gender-Affirming Surgical Care Access

Referred to: Reference Committee E

Whereas, gender-affirming surgeries (GAS) are medical procedures that involve altering an individual's physical appearance and function of their existing sexual characteristics to resemble those of their identified gender [1]; and

Whereas, GAS includes procedures for nonbinary, queer, cis-, and transgender individuals and include examples like top surgery (breast augmentation or mastectomy), bottom surgery (hysterectomy, and salpingectomy/oophorectomy, vaginoplasty, phalloplasty, or metoidioplasty), feminization or masculinization surgeries, and many others [2-3]; and

Whereas, unlike cis-gender-affirming surgery and care, nonbinary, queer, and trans-gender-affirming surgery and care have been considered controversial and received increased scrutiny and persecution in recent years [4-9]; and

Whereas, despite increased security, outcomes from GAS have noted high levels of surgical satisfaction, improved dysphoria, reduced mental health comorbidities, and improved quality of life [10-14]; and

Whereas, under the second Trump Administration, attacks on pediatric and adult gender-affirming care for nonbinary, queer, and transgender individuals have increased with an increase in legislation against GAS [4-9,15-21]; and

Whereas, on February 4, 2026, the AMA publicized a statement regarding gender-affirming surgery for patients under 19, following the American Society of Plastic Surgeons' statement change [22]; and

Whereas, this statement was a significant deviation from typical AMA statements, as it stepped into a specialty society space without active input from said specialty societies, nor did it involve AMA members with expertise in pediatric gender affirming surgery or inform AMA LGBTQ+ leaders of its publicization [23,24]; and

Whereas, the AMA has extensive policy supporting evidence-based gender affirming care [25]; and

Whereas, AMA policy H-185.927 states that "our AMA will work with state and specialty societies and other interested stakeholders to advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence [and] oppose laws and policies that criminalize, prohibit, or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care"; and

Whereas, AMA policy H-185.927 further states that our AMA will work with aforementioned stakeholders to "support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians"; and

Whereas, AMA policy H-160.991 states that "our AMA is committed to taking a leadership role in educating physicians on the current state of research in and knowledge of LGBTQ+ health… educating physicians to recognize the physical and psychological needs of LGBTQ+ patients… encouraging physicians to seek out local or national experts in the health care needs of LGBTQ+ people… and working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients"; and

Whereas, AMA policy H-60.927 states that "our American Medical Association will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) youth suicide and improve health among LGBTQ+ youth"; and

Whereas, AMA policy H-65.965 states that "our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life… reaffirms its longstanding policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, … opposes any discrimination based on an individual's sex, sexual orientation, gender identity"; and

Whereas, the American Academy of Pediatrics "does not include a blanket recommendation for surgery for minors. The AAP continues to hold to the principle that patients, their families, and their physicians—not politicians—should be the ones to make decisions together about what care is best for them" [26]; and

Whereas, expert guidance from the World Professional Association for Transgender emphasizes individualized care for medical and surgical care for transgender and gender diverse youth, with longitudinal patient-physician-guardian relationships, comprehensive biopsychosocial assessment, thorough health information and informed consent, multidisciplinary care, and only recommending gender-affirming surgical care to adolescents when meeting diagnostic criteria of gender incongruence that is sustained and marked, adolescent demonstration of emotional and cognitive maturity to provide informed consent/assent, thorough exploration of reproductive effects and fertility preservation options, and at least 12mo of gender-affirming hormone therapy to achieve the desired surgical result [27]; and

Whereas, research indicates that the rate of undergoing gender-affirming surgery for transgender and gender diverse minors is 2.1 per 100,000 minors ages 15-17 years, 0.1 per 100,000 minors aged 13-14 years, and 0 among minors 12 and younger [#]; and

Whereas, of the gender-affirming surgical procedures identified in transgender and gender diverse minors, 92 of 95 (96.4%) were chest-related procedures, and of the 151 breast reductions performed on cisgender male and transgender/gender diverse minors, 97% were performed on cisgender male minors [28]; and

Whereas, as gender-affirming mastectomy is the predominant surgical procedure performed in this small subset of gender diverse adolescents in the US, research on gender-affirming

mastectomy in adolescents had a median age at time of referral was 16 years, the documented regret rate was 0.95%, due in part to unsupportive home and social environment, and the prevalence of any surgical complications and revisions were comparable to or lower than rates in adults [29]; and

Whereas, gender-affirming surgical care is provided at significantly higher rates to cisgender youth, yet current political efforts explicitly target such surgical care only when provided to transgender and gender diverse youth, making these political efforts discriminatory by sex and gender identity [4-9, 30-33,]; and

Whereas, the aforementioned statement is technically in line with AMA policy, though its media manipulation counters best practice and existing research, thus leading to harm related to the statement that contradicts AMA policy; therefore be it

RESOLVED, that our American Medical Association reaffirm and recognize that decisions regarding gender-affirming surgical care rest with physicians, patients, and families, and support evidence-based, patient-centered, shared decision-making for such care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate and support funding and opportunities for gender-affirming care research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making gender-affirming surgical and medical care. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.
4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ

patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our American Medical Association will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-26)

Introduced by: North Carolina

Subject: Exosome and Peptide Use in Healthcare

Referred to: Reference Committee E

Whereas, Exosomes and Peptides are distinct regenerative tools: Exosomes serve as cellular "couriers" that deliver bioactive molecules to stimulate healing and regenerative processes, while Peptides are amino acid chains acting as targeted messengers to influence similar specific cellular functions as well; and

Whereas, Exosomes and Peptides can have many uses as they can contribute significantly to longevity, improved health and wound-healing processes through their antimicrobial, immunomodulatory and regenerative processes in all stages of aging and healing, including inflammation and wound healing; and

Whereas, currently there needs to be better guidance in the proper sourcing and use of Exosomes and Peptides, including supporting the manufacture of these substances domestically in the United States and transparent composition and strength of these products to guide proper dosing protocol; and

Whereas, the NDAA (National Defense Authorization Act) for FY2027 which includes funding for national defense, implements significant guidelines for buying equipment and products favoring “best value” over just lower cost, and includes provisions for improvements to healthcare for active military and veteran members is currently in a phase where amendments can be proposed and passed that can improve the healing of acute and chronic wounds as well as neurologic and psychological disease states that are a consequence of the service that these active Soldiers and Veteran members provide to defend our country and freedoms; therefore be it

RESOLVED, that our AMA take the lead in advising Congress, the FDA and our regulatory agencies in:

1) Categorizing Exosomes and Peptides by their longevity, wound healing and regenerative potentials.

2) Encouraging the manufacture and processing of Exosomes and Peptides in the United States.

3) Work with the FDA to reclassify Exosomes and Peptides to allow Physicians to order and dispense Exosomes and Peptides properly sourced in single dose syringes individualized to patients to treat appropriate patient medical concerns including wound healing, improved health and longevity.

4) Work with Congress to propose an amendment to the NDAA 2027 that addresses appropriate use of Exosomes and Peptides within the Armed Services and VA system to improve Soldier and Veteran Healthcare, especially in acute and chronic wound healing.

5) Encourage additional trials and testing of Exosome and Peptide use protocols to firmly establish their efficacy.

6) Refer this issue to the Council on Science and Public Health for study and report back at Interim 2026.
(Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-26)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, Society for Investigative Dermatology

Subject: Preserving Specialty Access to Anti-Cancer Agents

Referred to: Reference Committee E

Whereas, certain health systems have implemented restrictive policies that limit the prescription and administration of anti-cancer agents exclusively to the specialty of medical oncology; and

Whereas, these policies may be couched in concern for proper care and disposal of these agents but in practice they can be motivated by limiting patient access to treatment options as a cost control measure; and

Whereas, such restrictions can create unnecessary barriers to patient care, delay treatment, and overlook the clinical expertise of other specialists who are highly trained in the management of specific malignancies; and

Whereas, different anti-cancer agents have significantly different levels of concern about care, use and disposal, particularly comparing large-volume intravenous solutions of cytotoxic agents with oral agents prescribed for patient self-administration at home; and

Whereas, physicians in diverse specialties have been instrumental in the development and clinical trials of breakthrough targeted therapies for a variety of malignancies;[1] and

Whereas, physicians in multiple specialties outside of medical oncology contribute to clinical innovation by actively enrolling patients in and conducting studies on chemotherapeutic[2-6] and immunotherapeutic[7] agents for the treatment of malignancies; and

Whereas, the safe handling, transportation, administration, and proper disposal of chemotherapeutic and immunotherapeutic agents are critical components of patient and healthcare worker safety that should be governed by targeted institutional protocols regardless of the prescribing physician's specialty; therefore be it

RESOLVED, that our American Medical Association support multidisciplinary, evidence-based cancer care models and oppose categorical specialty-based restrictions on physician prescribing and/or administering anti-cancer agents when the physician is appropriately trained in their use and institutional safety standards are met (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of chemotherapeutic and other anti-cancer agents (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer agents based solely on specialty designation rather than clinical competency, training, and patient need. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

Practice Parameters - Their Relevance to Physician Credentialing H-410.987
1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges.
2. The documentation of adherence to, or intent to practice within, relevant practice guidelines should not be used as an additional criterion for the granting of general or procedure-specific clinical privileges unless and until a relationship between adherence to such practice guidelines and desired patient outcomes is adequately documented.
3. Practice guidelines developed by a particular medical specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice guideline by physicians not formally credentialed in that specialty or specialties. Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges.

Medical Specialty Board Certification Standards H-275.926
1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges.
1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a process for defining specialty-specific standards for knowledge and skills and offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as

those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Privileging for Ultrasound Imaging H-230.960
1. AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians;
2. AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice;
3. AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and
4. AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty.

Protecting the Prescriptive Authority of Plenary Licensed Physicians D-120.920
1. Our American Medical Association will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.
2. Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.
3. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.
4. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.
5. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 512
(A-26)

Introduced by: Senior Physicians Section

Subject: Medical Cannabis Use in Older Adults

Referred to: Reference Committee E

Whereas, cannabis consumption among older adults (aged 65 years and above) has risen markedly over the past two decades in the United States, increasing from 0.4 percent in 2006 to 7 percent in 2023[1,2]; and

Whereas, medical cannabis is now legal in thirty-eight states, with recreational cannabis permitted in twenty-four states[3]; and

Whereas, the approval and expansion of state medical cannabis laws throughout the United States have greatly increased both the availability and use of cannabis, especially through medical cannabis programs; and

Whereas, recent studies suggest a higher incidence of dementia among individuals who use cannabis[4,5]; and

Whereas, cannabis may offer therapeutic benefits for managing agitation in dementia patients, potentially serving as an alternative to antipsychotic medications[6,7]; and

Whereas, greater transparency regarding both the potential benefits and adverse effects of cannabis use in older adults would be valuable to physicians, particularly given the current paucity of research that is focused on this population[8,9,10]; and

Whereas, adequate physician education regarding appropriate prescribing, therapeutic indications, and potential adverse effects is needed; therefore be it

RESOLVED, that our American Medical Association support the development and publication of educational resources on medical cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage expanded research into the therapeutic uses of cannabis in older adults—such as for managing agitation in individuals with cognitive impairment—as well as its possible adverse effects. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/16/26

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RELEVANT AMA POLICY

D-95.949 Advocacy for More Protective Regulations on Distribution of Cannabis

1. Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation for cannabis-related harms or violations of law, be used exclusively for research, education, prevention, and treatment of cannabis-related harms, as well as expanding physician training opportunities to provide clinical experience in the screening, diagnosis, and treatment of cannabis misuse and cannabis use disorder.
2. Our AMA supports legislation and/or regulation of all cannabis products that:
   a. prohibit cannabis use in all places that tobacco use is prohibited, including in hospitals and other places in which health care is delivered;
   b. apply the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople as well as avenues for legal and financial penalties for marketing to youth;
   c. prohibit product claims of reduced risk or effectiveness as tobacco cessation tools;
   d. require the use of secure, child- and tamper-proof packaging and design, and safety labeling on all cannabis products;
   e. establish manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
   f. require transparency and disclosure concerning product design, contents, and emissions; and
   g. prohibit the use of characterizing flavors that may enhance the appeal of such products to youth.
3. Our AMA encourages state medical associations to strengthen existing cannabis marketing and advertising restrictions, including consideration of prohibitions on marketing and advertising to children.
4. Our AMA supports the review of conditions that states have approved to authorize cannabis for medical use and recommend the removal of those conditions without scientifically valid and well-controlled clinical trials supporting the use of cannabis.

[BOT Rep. 21, A-25]

H-95.952 Cannabis and Cannabinoid Research

1. Our American Medical Association calls for further adequate and well-controlled studies of cannabis and related cannabinoids, including Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (HDICs), in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that cannabis's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and

alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of cannabis, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include:
a. disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation;
b. sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes;
c. confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, as well as the use of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, especially among youth, adolescents, pregnant people, and people who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.
[CSA Rep.10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep.3, I-09; Modified in lieu of Res. 902; BOT Action in response to referred for decision: Res. 503, A-24 I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of Res. 434, A-19; Appended: Res. 913, I-19; Reaffirmation: A-22; Reaffirmed: Res. 212, A-23; Reaffirmed: CSAPH Rep. 6 I-23; Modified: Speakers Rep. 02, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

D-95.958 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

1. Our American Medical Association will send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use.
2. Our AMA will generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids.
3. Our AMA will support and encourage federal, state, and private sector research on the effects of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use.
4. Our AMA will encourage state regulatory bodies to enforce cannabis-related marketing laws as well as laws related to marketing of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids and to publicize and make publicly available the results of such enforcement activities.
5. Our AMA will encourage social media platforms to set a threshold age of 21 years for exposure to cannabis, and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, advertising and marketing and improve age verification practices on social media platforms.
6. Our AMA will encourage regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids marketing.

7. Our AMA will support using existing AMA channels to educate physicians and the public on the health risks of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to children and potential health risks of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to people who are pregnant or lactating.
8. Our AMA will work with relevant stakeholders to strengthen cannabis marketing and advertising regulations, including efforts to ensure that packaging does not appeal to youth and marketing is restricted to prevent exposure to young audiences.
9. Our AMA opposes cannabis and cannabis-based product advertising that includes claims or statements that are not supported by peer-reviewed scientific evidence.
10. Our AMA will continue to monitor regulatory approaches to cannabis marketing.

[Res. 501, A-22; Modified: CSAPH Rep. 6, I-23; Appended: BOT Action in response to referred for decision Res. 508, A-24; Appended: CSAPH Rep. 01, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

D-95.969 Cannabis Legalization for Medicinal Use

1. Our American Medical Association believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products, Derived Psychoactive Cannabis Products (DPCPs), and Hemp-Derived Intoxicating Cannabinoids for medical use.
2. Our AMA believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process.
3. Our AMA will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process.
4. Our AMA supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws.
5. Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.
6. Our AMA will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.
7. Our AMA encourages hospitals and health systems to:
    a. not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use.
    b. educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

[CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19; Reaffirmed: Res. 212, A-23; BOT Action in response to referred for decision: Res. 503, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-26)

Introduced by: Texas

Subject: Access, Affordability, and Safety of GLP-1 Receptor Agonists

Referred to: Reference Committee E

Whereas, GLP-1 receptor agonists (e.g. semaglutide, tirzepatide, liraglutide) are FDA-approved medications that have demonstrated significant benefit for patients with type 2 diabetes and obesity, improving glycemic control, reducing cardiovascular risk, and promoting clinically meaningful weight loss; and

Whereas, the American Diabetes Association's Standards of Medical Care in Diabetes recommend GLP 1 receptor agonists as a preferred therapeutic option for patients with type 2 diabetes who have established cardiovascular disease, high cardiovascular risk, or require additional weight reduction, thereby establishing their role in evidence-based treatment algorithms; and

Whereas, obesity and diabetes are major public health burdens in Texas, contributing to increased morbidity, mortality, and health care costs, particularly among underserved and high-risk populations; and

Whereas, despite their proven clinical effectiveness, GLP-1 receptor agonists are often placed on higher formulary tiers with restrictive prior authorization criteria and prohibitively high out-of-pocket costs, limiting patient access; and

Whereas, many Americans face high deductibles or lack insurance coverage, leading some to seek compounded versions of GLP-1 receptor agonists; and although compounding can expand access, these preparations are not FDA-approved, may vary in purity or potency, and should be subject to clear, consistent regulatory oversight to promote patient safety; and

Whereas, the current pricing of GLP-1 receptor agonists has contributed to rising health care costs for both public and private payers, with annual out-of-pocket expenses for uninsured patients often exceeding $12,000, while manufacturers of GLP-1 agents have reported combined global revenues exceeding $50 billion in 2024; and

Whereas, large health systems and self-funded employers across Texas have curtailed GLP-1 coverage due to cost, including the University of Texas System, whose monthly spending on GLP-1 medications rose from $1.5 million to more than $5 million over 18 months; and

Whereas, the free market has not succeeded in making these life-changing medications broadly affordable to the patients who need them most, and meaningful price reductions will likely require greater governmental oversight, negotiation, or regulatory intervention to promote fair pricing and equitable access; and

Whereas, while GLP-1 receptor agonists have proven benefits in the management of type 2 diabetes, their widespread adoption for obesity management is relatively new, with limited long-term data and potential for weight regain after discontinuation; and

Whereas, sustainable obesity management requires comprehensive approaches including nutrition, physical activity, behavioral support, and long-term follow-up to promote durable success; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and/or regulation so that public and private health insurers provide GLP-1 receptor agonists for the treatment of type 2 diabetes and obesity at affordable formulary pricing, thereby reducing out-of-pocket costs for patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support regulatory oversight and quality-assurance standards for compounding of GLP-1 receptor agonists to promote patient safety while maintaining access for those who cannot otherwise afford FDA-approved medications (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for pricing transparency and cost-containment strategies among manufacturers, payers, and policymakers to improve affordability and access to evidence-based obesity and diabetes treatments (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications, within comprehensive care plans that include behavioral and lifestyle interventions. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

RELEVANT AMA POLICY

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.

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-26)

Introduced by: Texas

Subject: Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy

Referred to: Reference Committee E

Whereas, maternal morbidity and mortality are increasing despite quality improvements, with evidence showing there is a correlation between the prevalence of obstructive sleep apnea (OSA) and associated adverse pregnancy outcomes in the obstetrical population; and

Whereas, after controlling obesity and other potential confounders, OSA was associated with increased odds of pregnancy-related morbidities including preeclampsia, eclampsia, cardiomyopathy, and pulmonary embolism with more than fivefold increased odds of in hospital mortality; and

Whereas, during late pregnancy women with OSA had eight times the odds of having depressive symptoms; and

Whereas, OSA has been associated with adverse neonatal outcomes, such as preterm birth and growth restriction in some studies; and

Whereas, OSA in pregnancy continues to be underdiagnosed, resulting in missed opportunities to prevent adverse outcomes; and

Whereas, it is important to screen for OSA in women, and if clinically indicated, order a home sleep test which can be shipped to the patient's home and follow-up care can be provided via telemedicine until OSA resolves to improve maternal health; therefore be it

RESOLVED, that our American Medical Association adopt policy to screening and educating about obstructive sleep apnea:

That AMA supports obstructive sleep apnea screening to reduce negative outcomes
That AMA supports physician payment for obstructive sleep apnea screening and treatment.
That AMA advocates for more research on obstructive sleep apnea in pregnancy.
That AMA supports education about obstructive sleep apnea in pregnancy.

(New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation aligning with this policy. Routine screening, early diagnosis, and effective treatment of obstructive sleep apnea are recommended in pregnant women, particularly during mid and late pregnancy. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

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RELEVANT AMA POLICY

H-290.953 State Medicaid Coverage of Home Sleep Testing
Our American Medical Association supports efforts to expand access to and insurance coverage of physician-ordered home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions.

H-35.963 Appropriate Use of Objective Tests for Obstructive Sleep Apnea
It is the policy of our AMA that: (1) ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring constitutes the practice of medicine; (2) the need for, and appropriateness of, objective tests for purposes of diagnosing OSA or primary snoring or evaluating treatment efficacy must be based on the patient's medical history and examination by a licensed physician; and (3) objective tests for diagnosing OSA and primary snoring are medical assessments that must be ordered and interpreted by a licensed physician.

H-440.795 Obstructive Sleep Apnea
1. Our American Medical Association recognizes Obstructive Sleep Apnea (OSA) as a major public health issue.
2. Our AMA encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups.
3. Our AMA encourages research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases.
4. Our AMA encourages that all physicians become knowledgeable about the diagnosis and management of OSA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-26)

Introduced by: Association for Clinical Oncology

Subject: Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure

Referred to: Reference Committee E

Whereas, health plans increasingly utilize augmented intelligence (AI) and algorithmic black box tools to issue adverse determinations, often relying on datasets that fail to reflect monthly updates in oncology clinical guidelines (e.g., National Comprehensive Cancer Network, American Society of Clinical Oncology (ASCO)); and

Whereas, the ASCO 2025 Position Statement on AI in Prior Authorization explicitly calls for federal and state legislation mandating proper disclosure regarding the use of AI in coverage determinations; and

Whereas, current American Medical Association human-in-the-loop policy ensures a physician makes the final call, but does not mandate that the payer disclose the specific clinical logic or version history necessary for a physician to successfully appeal a denial; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians with the specific clinical logic, evidence-based sources, and version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited to ensure it reflects the most recent peer-reviewed clinical guidelines and recognized standards of care. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

REFERENCES
1. American Society of Clinical Oncology. Safeguarding AI Use in Prior Authorization: ASCO Position Statement. June 11, 2025. https://www.asco.org/news-initiatives/policy-news-analysis/safeguarding-ai-use-in-prior-authorization
2. Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). Effective January 1, 2026. https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
3. American Medical Association. AMA Center for Digital Health and AI. March 2026. https://www.ama-assn.org/about/ama-center-digital-health-and-ai

RELEVANT AMA POLICY

H-480.939 Augmented Intelligence in Health Care
Our AMA will advocate that: Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: transparency; evidence of safety, efficacy, and equity; and level of automation. 2. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it. [Res. 611, A-19; Reaffirmed: 2025]

D-480.952 Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence
Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care... [and] advocates that entities provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs. [Council on Science and Public Health Rep. 02, A-24; Modified: June 2025]

H-320.939 Prior Authorization and Utilization Management Reform
Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. [Sub. Res. 701, A-17; Reaffirmed: 2026]

Reference Committee F

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01 Report of the House of Delegates Committee on the Compensation of the Officers

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604 Annual Scorecard to Evaluate the AMA's Impact
605 Review of Past Resolutions
606 Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
607 Shortening the AMA House of Delegates Endorsement Process and Timeline
608 Reinstitution of AMA Guides Editorial Panel
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610 Plant-Based Diets at AMA meetings
611 Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices
612 Increasing Expert Guidance in AMA Statements
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614 Inclusive Policy Language for Older Adults
615 Condemnation of Attacks on Healthcare Workers and Facilities in Gaza
616 Humanitarian and Medical Aid Support to Palestine
617 Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association
618 Ending AMA Investment in Weapons Manufacturers

REPORT OF THE BOARD OF TRUSTEES

BOT Report 01-A-26

Subject: Annual Report

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee F

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

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AMA
AMERICAN MEDICAL ASSOCIATION

PHYSICIANS' POWERFUL ALLY

IN PATIENT CARE

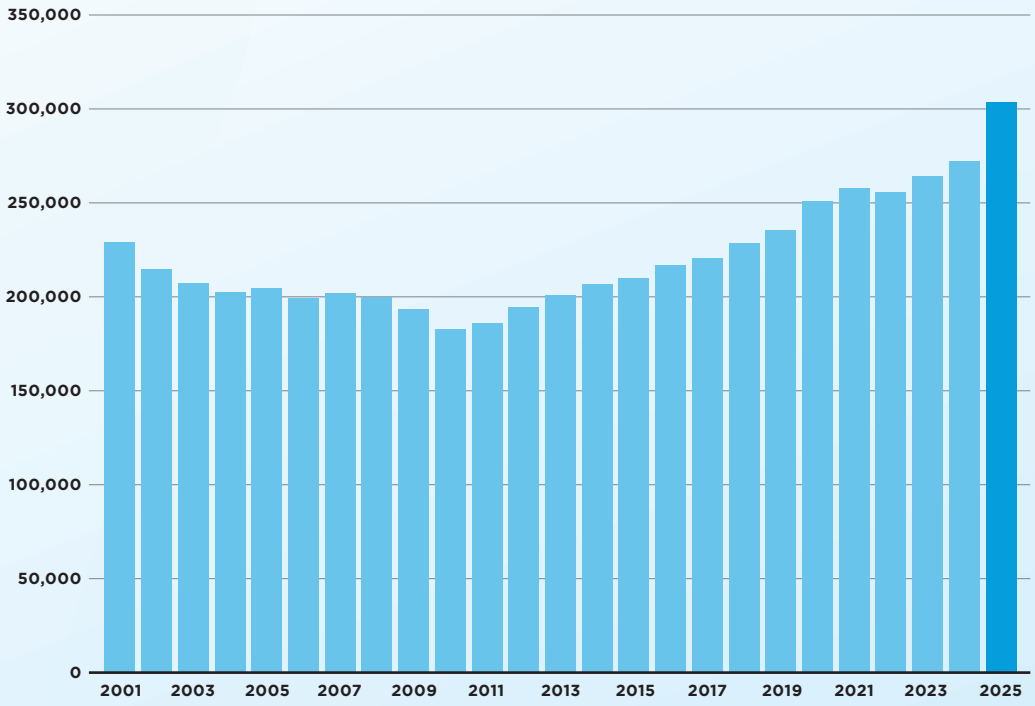
2025 ANNUAL REPORT

FINANCIAL HIGHLIGHTS

(Dollars in millions)	2025	2024
Revenues	$ 536.4	$ 513.2
Cost of products sold, selling and general and administrative expenses	463.8	458.0
Net operating results	68.7	51.1
Non-operating items	109.8	74.1
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	(11.4)	2.0
Change in association equity	167.1	127.2
Change in association equity - donor restricted	(0.1)	0.1
Change in total association equity	$ 167.0	$ 127.3
Association equity at year-end	$ 1,317.7	$ 1,150.7
Employees at year-end	1,316	1,331

AMA MEMBERSHIP

(Dues-paying members)



LETTER TO STAKEHOLDERS

In a period of disruption and change across health care, it is increasingly clear that physician leadership is vital to the future of medicine.

Patients are navigating a system under strain. Physicians are facing mounting administrative burdens, workforce pressures, and an erosion of trust in science and medical expertise. And decisions that shape care—how it is delivered, paid for, regulated and transformed by technology—are being made every day. At this moment, physicians cannot afford to be observers of change. We must be its architects.

In 2025, with high-profile challenges to clinical guidelines, public health decisions and research priorities, the American Medical Association (AMA) stood firm in the belief that evidence must guide care. That commitment is foundational not only to the profession, but also to the trust patients place in their physicians.

As the nation's largest and most trusted physician organization, the AMA brought together leaders across states, specialties and practice settings to confront some of the most pressing challenges in health care. We pushed back against threats to medical research, defended clinical autonomy, protected patient privacy and worked to remove barriers that often prevent patients from accessing high-quality care. At the same time, we advanced a new strategic vision for the organization centered on three imperatives: modernizing physician education and training, strengthening the physician workforce, and ensuring that clinical expertise leads the transformation of digital health.

That work was grounded in a simple but powerful belief that the future of medicine is not something physicians can wait for. It must be shaped—deliberately and collaboratively—by those who understand care best.

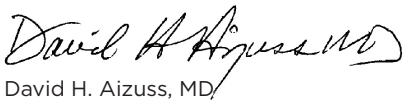
This ethos led to the AMA's creation of two physician-led initiatives in 2025, one focused on improving health outcomes locally and the other designed to embed physician expertise in the expansive world of health technology. The AMA's new Community Health Impact Lab grants are a $1 million investment to fund 20 physician-led initiatives to address health needs in the communities they serve. The AMA's new Center for Digital Health and AI was created to give physicians a platform to help establish ethical guardrails, shape policy and support workflow integration so that AI and other digital tools enhance care rather than complicate it. In public health and technology, physicians should not be reacting to change. They must lead.

In advocacy, the AMA partnered with dozens of state and specialty medical societies to defeat nearly 100 bills that would have placed patients at risk by expanding scope of practice by non-physicians beyond their appropriate training. We continued to press for Medicare payment reforms that reflect the true cost of delivering care. We advanced prior authorization reforms and made physician well-being a priority across the country.

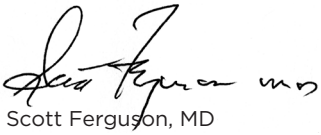
In education, the AMA announced a $12 million investment in a new precision education grant program, designed to create personalized, data-driven learning experiences that better prepare physicians for modern clinical practice. From the moment students consider medicine to the day physicians retire, lifelong learning must evolve alongside the realities of care.

AMA's advocacy and mission activities were fueled by another strong year of financial performance and the reach of our voice online. AMA membership eclipsed 300,000 for the first time since the AMA began modern membership tracking, and the number of people reading, watching and listening to our content grew by 3% to more than 31 million.

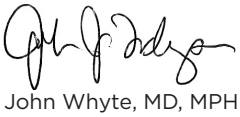
At this consequential moment, medicine needs physicians to lead—together. By speaking with a unified voice, grounding decisions in clinical expertise, and embracing innovation with purpose, physicians can shape a future for medicine that better serves patients and strengthens our profession for generations to come.



David H. Aizuss, MD
Chair, Board of Trustees



Scott Ferguson, MD
Finance Committee Chair, Board of Trustees



John Whyte, MD, MPH
CEO and Executive Vice President



DRIVING DIGITAL HEALTH WITH CLINICAL EXPERTISE

The rapid changes in digital health and augmented intelligence (AI) over the last few years accelerated even more in 2025.

As a growing number of physicians and health systems adopt AI tools, they're experiencing, first-hand, the potential for this technology to transform how they care for patients.

And yet, we've only scratched the surface of what's possible with AI and digital health. Going forward, it's going to be more important than ever that physicians be at the center of shaping, guiding and implementing these transformative technologies.

With the launch of the AMA Center for Digital Health and AI in 2025, we're taking the lead in this space. The new center is focusing on:

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



2 out of 3

physicians use AI-enabled tools in some form



84%

of physicians say EHR integration is key to advance adoption of AI tools

- **Collaboration:** Building partnerships across the tech, research, government and health care sectors to drive innovation aligned with patient needs.

Physicians are excited about the possibilities of AI, but they're also aware of how it still needs to evolve and the issues that must be addressed. Their voice must guide the development of AI in health care to ensure this technology supports physicians, improves patient care and changes medicine for the better.



AMPLIFYING PHYSICIAN VOICES

AND SHAPING POLICY

In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C., and across the country—because physicians play a leading role in shaping the future of health care.

At the national level, the AMA continued its critical work to push for Medicare payment reform, fix prior authorization, promote physician-led care and more by:

- **Generating more than 100 million in earned media and ad impressions** and driving more than 100,000 emails last year alone from physicians and patients to their legislators about Medicare payment reform through our Fix Medicare Now grassroots campaign.

- Facilitating a commitment from AHIP and the Blue Cross Blue Shield Association to **lessen the burden of prior authorization** in 60 of their member plans.

- **Opposing legislation** that would expand pharmacists' scope of practice with respect to testing and treating patients for influenza, COVID-19, RSV and strep throat.

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

- **Blocking more than 95 bills** that would have inappropriately expanded the scope of practice for physician assistants, pharmacists, optometrists and more.

- **Supporting the passage of more than 20 state laws** that reduce care delays caused by prior authorization.



620,000

contacts to Congress in total through FixMedicareNow.org



95+

scope of practice bills defeated nationwide

- **Increasing advocacy efforts with the Dr. Lorna Breen Heroes' Foundation** to verify that more than 40 state medical boards and more than 1,800 health systems (and others) removed stigmatizing mental health and substance use questions from their licensing and credentialing applications.

Whenever and wherever policymakers were discussing issues that impact patients and physicians, the AMA was there. For a comprehensive look at our accomplishments across the country, check out our 2025 State Advocacy Impact Report.

STANDING UP FOR SCIENCE
AND ELEVATING EXPERTS

In a year where public health was marked by near-constant change, the need for physician leadership was greater than ever—and the AMA answered the call.

We were a steady voice amidst uncertainty and doubt. We defended science and maintained that evidence should guide care decisions and public health policy. We did that by:

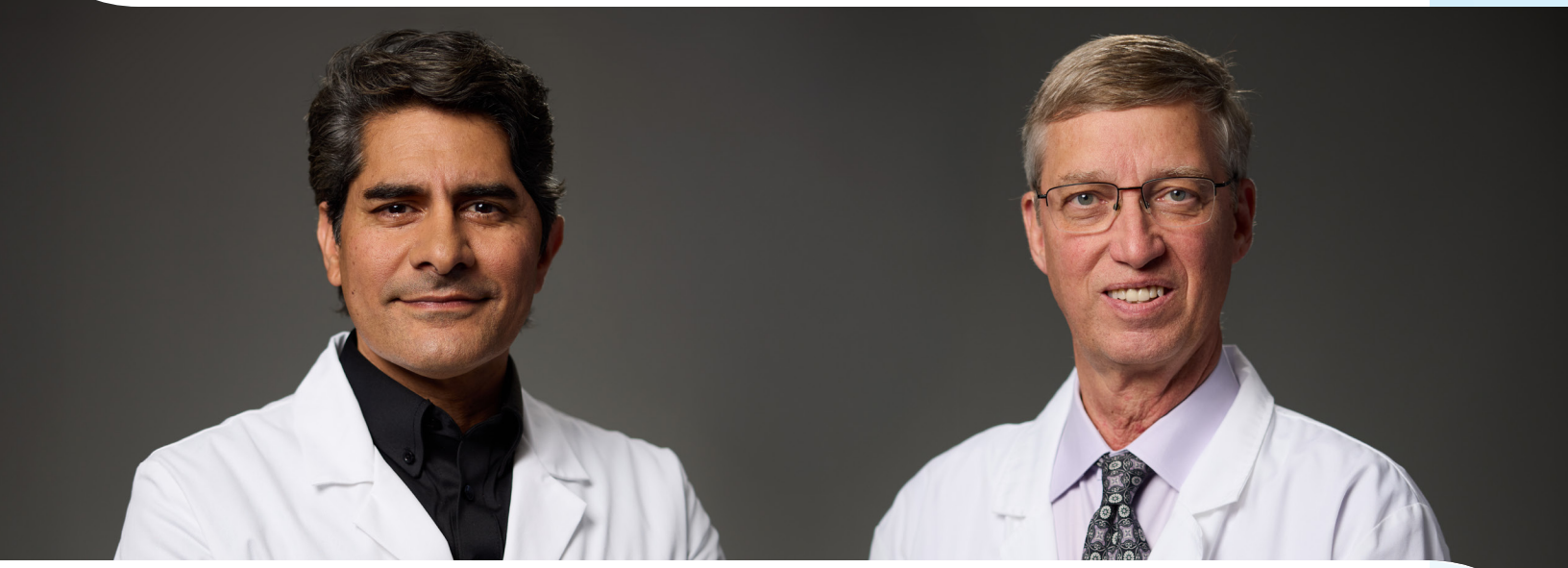
- **Amplifying expert voices** and opposing efforts to destabilize the nation's public health infrastructure.
- **Elevating science** and science-based policy through statements and social media—all backed by action.

The AMA will always ensure that the voice of physicians is heard loud and clear and stand resolute in our defense of science-based medicine.



"With measles outbreaks occurring in multiple states and spring break travel approaching, the AMA urges everyone who isn't already vaccinated to get themselves and their families vaccinated against measles now."

—Bruce A. Scott, MD
Immediate Past President, AMA



"In the wake of CDC budget cuts and the termination of hundreds of employees earlier this year, the AMA is deeply concerned that this turmoil leaves us highly susceptible to public health threats."

—Bobby Mukkamala, MD
President, AMA



TURNING PHYSICIANS INTO CATALYSTS FOR CHANGE

Administrative burdens like prior authorization aren't the only barriers physicians must overcome when treating patients.

For example, health disparities like food deserts or a lack of safe housing within communities can have as much impact on patients' health as anything that happens in the exam room.

That's why the AMA launched its first Community Health Impact Lab micro grants in 2025—as a way to invest in physicians who have ideas to address barriers they see in their communities with local, creative and measurable solutions.

LEADING CONVERSATIONS ON THE FUTURE OF CARE

For physicians to be architects of change, they need to be more than involved in conversations about the future of care. They need to be driving them.

The AMA's original reports, research, trusted analysis and resources help physicians stay informed and prepared to do exactly that.

In 2025, the AMA published a wide range of content that shared new insights on some of the biggest trends in health care and solutions to some of today's most pressing problems.

This research and other reports, like our annual survey on prior authorization and our update on the overdose epidemic, cement the AMA as the definitive voice of medicine and an authoritative resource for policymakers, journalists and academic institutions.



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

This initiative brings together the unique insights physicians have about the health challenges in their communities with the support they need to be a catalyst for change.

Recipients of the micro grants were notified in April of 2026. They will have 12 months to turn their ideas into action, with the AMA providing advice and coaching along the way.

20
physician-led initiatives supported

$1 million
in micro grants awarded

MANAGEMENT'S DISCUSSION AND ANALYSIS

MANAGEMENT'S DISCUSSION AND ANALYSIS

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic focus is centered on advocacy, membership, financial performance, and operational excellence. Our advocacy; support for optimal health outcomes; putting physicians at the center of shaping, guiding and implementing technologies transforming medicine; growing our national and social media presence as well as several other new initiatives will ensure that our AMA achieves success.

2025 was a transformative year with a mid-year change in leadership driving the start of a transition toward our new priorities. At the same time, AMA continued efforts to re-build health care so that it works better for physicians and all those they serve: 1) reforming Medicare payment to promote thriving physician practices and innovation; 2) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 3) promoting physician-led care as health care teams working together—with physicians in the lead—is critical to having the best and safest outcomes for patients; 4) reducing physician burnout and addressing the stigma around mental health; and 5) working to ensure physician voices are integrated into the creation and refinement of all medical technology to make technology an asset to physicians, not a burden.

For example, through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, providing grants for key state fights, and directly assisted in the defeat of almost 100 problematic bills. The AMA's Fix Medicare Now campaign delivered strong results with over 100 million earned media and ad impressions and more than 600 thousand contacts to Congress.

The results for both 2021 and 2022 included in this report were dramatically impacted by the COVID-19 pandemic. Early in 2020, the AMA, like all other organizations, recognized that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty. AMA lifted a freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 as the job market was very tight. Vacancies and limited travel for most of the three years garnered substantial savings that were temporary in nature resulting in unusually high operating income for AMA. Results began to normalize in 2023, although better than expected revenue growth and a slower ramp up than expected in operating expenses continue to drive a higher level of net operating income through 2025 than experienced in the past.

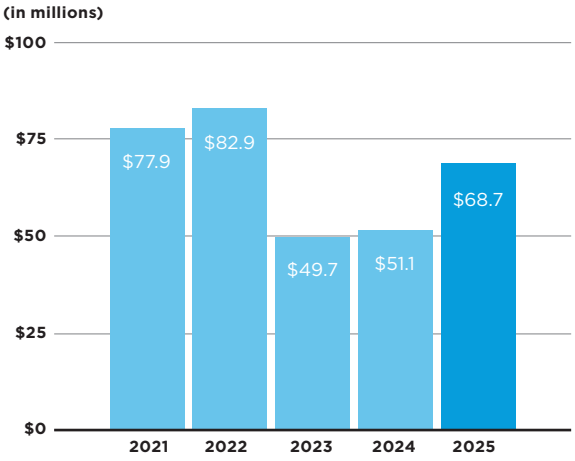
The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on its core mission activities while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

The following pages discuss the 2025 consolidated financial results as compared to 2024. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results



As noted above, the hiring freezes and remote work during the pandemic and an unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings through 2022 were major factors in spending levels running substantially less than budgets. Spending levels began to normalize in 2023 although open positions remained higher than previously experienced.

In both 2024 and 2025, revenue growth more than offset a continued increase toward normalized spending levels, resulting in continued unusually strong operating results when compared to historical levels.

Revenues

In 2025, total revenue increased $23.2 million over the prior year. Continued growth in AMA's royalties and investment income as well as improved coding book sales, membership dues and advertising revenue were partially offset by declines in print subscriptions and insurance commission revenue.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2025, mainly due to a larger invested asset base. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased by 11.5 percent in 2025, the 14th year of growth in the past 15 years. During that 15-year period, AMA dues paying membership increased by over 121,000. Dues revenue increased 1.5 percent in 2025 as much of the growth was in lower dues paying categories such as group memberships and sponsored memberships.

Most other revenue categories were largely unchanged for the year.

Cost of products sold and selling expenses

All variable expenses related to production, distribution and sale of periodicals, books, coding products, and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs, and third-party editorial costs.

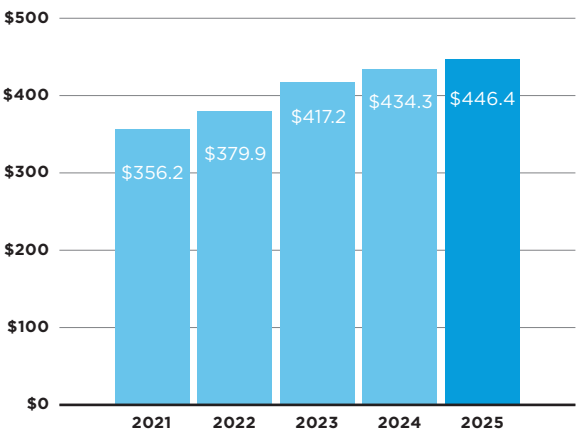
In 2025, cost of products sold and selling expenses decreased $6.3 million from the prior year. Most of the decrease was due to reclassifying certain editorial costs to outside professional services, coupled with additional savings from eliminating distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for print ad placement.

Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $29.5 million to $519 million in 2025, a combination of the $23.2 million revenue improvement coupled with the reduction in cost of products sold noted above.

General and administrative expenses



General and administrative expenses rose $12.1 million in 2025, or 2.8 percent, when compared to 2024. This was substantially less than the $44.9 million increase budgeted for 2025, with approximately $33 million of under budget spending in almost all categories of spending, with the largest variances in marketing and promotion and outside professional services.

Compensation and benefits increased $8.4 million in 2025, up 3 percent. Compensation, including temporary help, was $9.1 million higher in 2025, a 4.8 percent increase which was a function of annual merit increases and filling open positions. Fringe benefit costs increased $2.7 million in total primarily due to higher medical and payroll tax expenses. Incentive compensation decreased $3.2 million as certain key performance indicators were rated lower than the prior year.

Occupancy costs were down $2.3 million, driven by a reduction in rent expense. In late 2023, AMA negotiated an extension of the current headquarters lease in return for future contraction options and lease incentives. Most of the reduction in occupancy was related to rent abatement from the renegotiation and a reduction in real estate taxes due to a change in valuation of the building.

Travel and meeting costs increased by $2.5 million in 2025 due to holding several large biennial meetings such as the International Congress on Peer Review and Scientific Publication and the ChangeMedEd® National Conference, as well as inflationary cost pressures.

Technology costs were largely unchanged. As more technology moves to the cloud, costs associated with the technology platforms will be reflected in operating expense instead of capitalized as an asset and depreciated. This model has the benefit of reducing the need for in-house development expertise but also exposes AMA to more price risk from vendors.

Marketing and promotion costs decreased $2.5 million in 2025, as Advocacy had expanded its grassroots and media campaign activity on Medicare payment reform in 2024, but returned campaign spending back to previous levels in 2025.

Outside professional services increased $1.9 million in 2025, as a substantial decline in the use of outside consulting in the Core Mission Activities and Health2047 was offset by a reclassification of certain editorial costs from cost of products sold.

Other operating expenses increased $3.8 million in 2025 due primarily to recognizing a $4.5 million loss related to divesting most of Health2047's investment in an affiliate.

Operating results before income taxes

The AMA reported $72.6 million in pre-tax operating income in 2025 compared to $55.2 million in 2024. The current year results include over $23 million in revenue growth that was only partially offset by higher spending, the latter a continuation toward budgeted expense levels.

Income taxes

Taxes decreased $0.2 million in 2025 when compared to 2024, reflecting lower taxable income in one of the for-profit subsidiaries.

Net operating results

Net operating income was $68.7 million in 2025 compared to $51.1 million in 2024, as revenue growth was only partially offset by higher spending.

Non-operating items

The AMA reported a $113.8 million gain in the fair value of its portfolio during 2025. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard for postretirement benefit plans, non-operating results include $6.1 million in postretirement plan interest expense in 2025 and $5.7 million of plan interest expense and recognized actuarial losses in 2024. In 2025, AMA also recognized a $2 million gain on the liquidation of a Health2047 spin out company.

Revenue in excess of expenses

Revenues exceeded expenses by $178.5 million in 2025, a combination of $68.7 million in operating income, a $113.8 million gain in fair value in the portfolio and $4 million in other non-operating expenses. In 2024, revenues exceeded expenses by $125.2 million, a combination of $51.1 million in operating income, a $79.7 million gain in fair value in the portfolio and $5.6 million in other non-operating expenses.

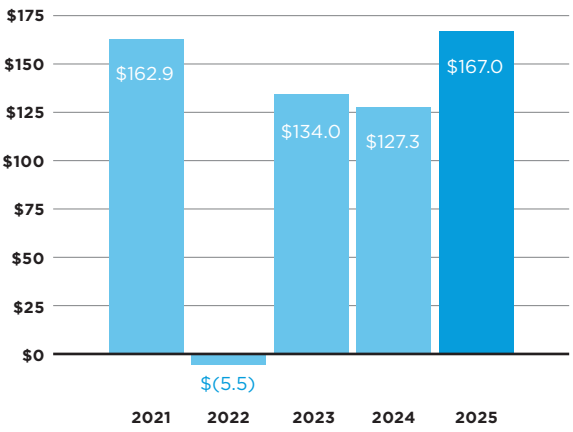
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2025, AMA recorded an $11.4 million charge to equity reflecting an actuarial loss for the postretirement health care plan, net of income tax. A change increasing the initial health care cost trend in 2025 and adverse claims cost experience were the major drivers of the actuarial loss in 2025.

In 2024, AMA recorded a $2 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The gain resulted primarily from a change in interest rates from 5 percent to 5.7 percent which reduced the present value of projected liabilities, offset by higher claims cost experience.

Change in total association equity

(in millions)



The AMA reported a $167 million increase in association equity in 2025. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a slight decrease in donor-restricted equity.

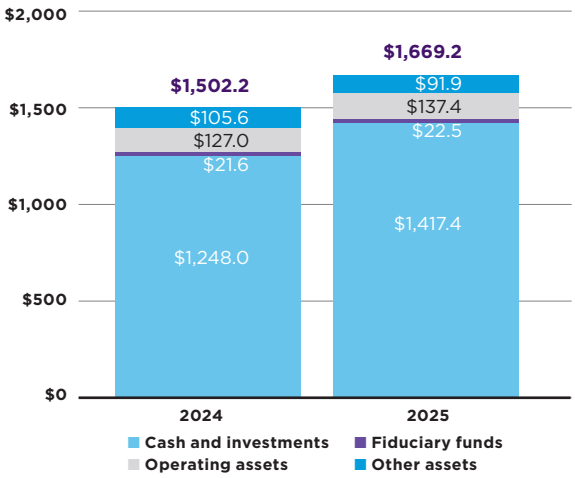
The AMA reported a $127.3 million increase in association equity in 2024. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a slight increase in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents, and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, information technology hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities, and deferred revenue.

Assets

(in millions)



The AMA's total assets increased $167 million in 2025. This includes a $169.4 million increase in cash and investments resulting from $58.7 million in free cash flow plus a $113.8 million gain in the fair value of investment securities less $3.1 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $10.4 million in 2025, primarily due to increases in accounts receivable and prepaid software licensing expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets include operating lease right-of-use assets, property and equipment, investment in affiliates and investments in mutual funds maintained in separate accounts designated for various non-qualified benefit plans that are not available for operations. The right-of-use assets declined by $9.2 million, which included $4.8 million in amortization of the asset and a $4.9 million reduction related to the early termination of the existing Washington D.C. office lease in anticipation of a 2026 move to a new space, offset by a $0.5 million increase for a new satellite office lease.

Property and equipment net book value decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities increased $1.4 million in 2025, led by an increase in the postretirement health care liability. This was largely offset by a $3.8 million decrease in accrued expenses and a $10.9 million reduction in the lease liability from cash payments exceeding rent expense and a reduction in liability due to terminating the existing Washington D.C. office lease. The new lease in D.C. will not begin until 2026.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

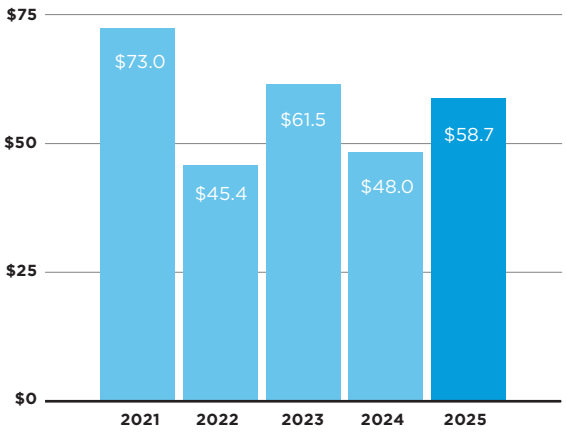
Cash flows

Cash, cash equivalents and donor-restricted cash increased $6.8 million and $3.5 million in 2025 and 2024, respectively. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

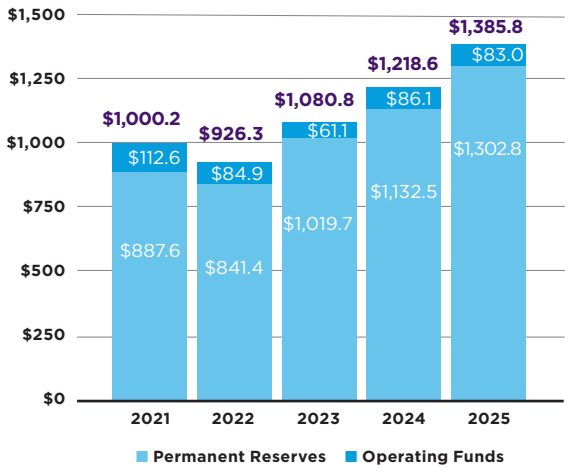


Free cash in 2025 totaled $58.7 million, $10.7 million greater than 2024, a result of higher cash operating income offset by changes in operating assets and liabilities.

Reserve portfolio

Reserves and operating funds

(in millions)



The reserve and operating fund portfolios above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

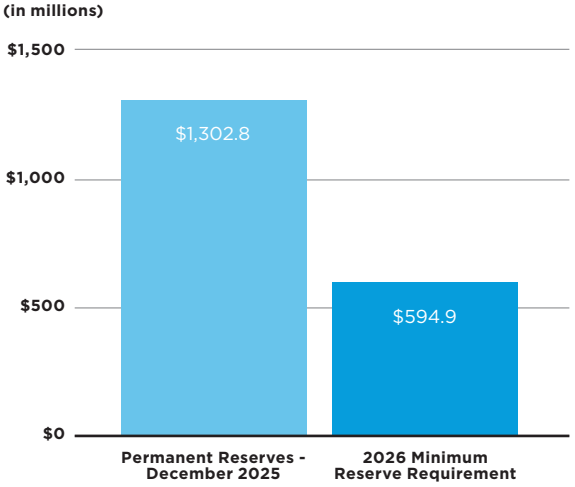
As of year-end 2025, the reserve portfolio's value was $1,302.8 million compared to $1,132.5 million in 2024, a $170.3 million increase. That increase was mainly the result of a $112.8 million gain in the fair value of the reserve portfolio plus a $56 million transfer of 2024 excess operating funds to reserves. Operating funds totaled $83 million in 2025, down $3.1 million from 2024.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

AMA's reserves provide the backbone for the organization's long-term viability and independence, currently operating as a quasi-endowment fund, with a goal of achieving levels that could generate adequate funding to ensure the long-term future of the organization. Building these reserves to function as an endowment fund will provide considerable protection against future loss of revenue and maintain AMA's independence over the long term.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from reserve funds is limited to dollar- or time-limited initiatives and capped at the amount by which reserves exceed the minimum requirement. Reserves may not be used for ongoing operating expenses. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiary). Revenues and expenses directly attributed to those units are included in the group operating results.

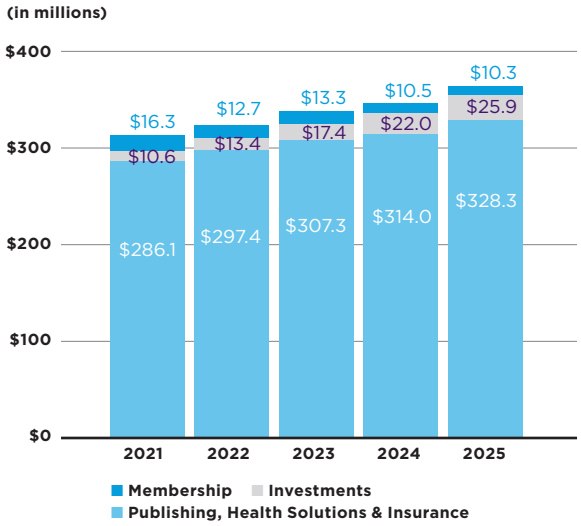
A financial summary of group operating results is presented at the end of this section. The prior year financial results have been updated to be consistent with the current year reported results for each group.

Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs, and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts on the following pages separate groups with contribution margin from groups with net expenses.

Contribution margin



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's net membership dues revenue includes the gross dues revenue collected, reduced by any commissions paid to state societies, and equals the membership dues revenue reported on the statement of activities.

In 2025, AMA again reported an increase in the number of dues-paying members, up 11.5 percent from 2024. In 14 of the last 15 years, AMA has reported increases in the number of dues-paying members, a major accomplishment. Membership continues to focus on broad use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and expanding AMA's reach to physicians through important programmatic mission-based activities.

Dues revenue was $33 million, a $0.5 million increase from 2024. Although the number of post-training physician members increased substantially, most of the growth was in lower dues paying categories. Membership expenses are up $0.7 million from staffing expenses related to merit and open positions as well as higher membership solicitation costs. As a result, Membership's contribution margin decreased $0.2 million in 2025.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network® include the *Journal of the American Medical Association* (*JAMA*®) and the JAMA Network specialty journals. In the last 11 years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees, and royalties. Publishing revenues increased $2.5 million in 2025, largely a function of a $1.4 million increase in open access fees resulting from pricing changes and a $1 million increase in advertising revenue and site licensing fees. Expenses in total rose $2.2 million during 2025, as the cost of filling open positions and merit increases were only partially offset by reduced production costs related to eliminating print journals. The contribution margin improved by $0.3 million to $0.4 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2025, up $0.4 million when compared to 2024. Growth in credentialing revenues, including revenues from a new credentialing product, VeriCre™, drove the revenue improvement. VeriCre is a credentials wallet that streamlines credentialing by pre-filling physician applications with authoritative, verified AMA data, reducing administrative burden for physicians and medical staff professionals. Total expenses were up $1.6 million, of which $0.9 million relates to development of the new physician credentialing product. The remaining $0.7 million cost increase was driven by filling open positions, and technology projects. The resulting contribution margin declined by $1.2 million in 2025 to $51.4 million.

AMA-published books and coding products, such as coding books and tools, workshops, and licensed data files, make up the Books and Digital Content unit. Royalties, coding book sales, and digital content sales drove a $15.9 million revenue increase, as the market for electronic use of digital coding products continues to expand. A three percent price increase as well as phasing in previous pricing model changes were also factors. Expenses were down $0.5 million, driven by a reduction in professional services for projects related to content and product strategy, market research, and project management. The contribution margin increased by $16.4 million to $267.5 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenue declined by $0.9 million in 2025, mainly due to lower interest income. A dividend from the Agency to AMA reduced the investible funds balance, with a resulting decline in investment income. The Agency, as broker, receives a commission on insurance policies sold, which declined slightly in 2025, flattening a trend of larger commission revenue declines in previous years. Expenses were down $0.4 million mainly due to staff and occupancy reductions. The contribution margin decreased to $13.3 million from $13.8 million in the prior year.

Other business operations net expenses were up $0.7 million in 2025 due to staffing and professional service expense increases.

In total, Publishing, Health Solutions & Insurance contribution margin was $328.3 million, up $14.3 million from 2024.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's for-profit subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

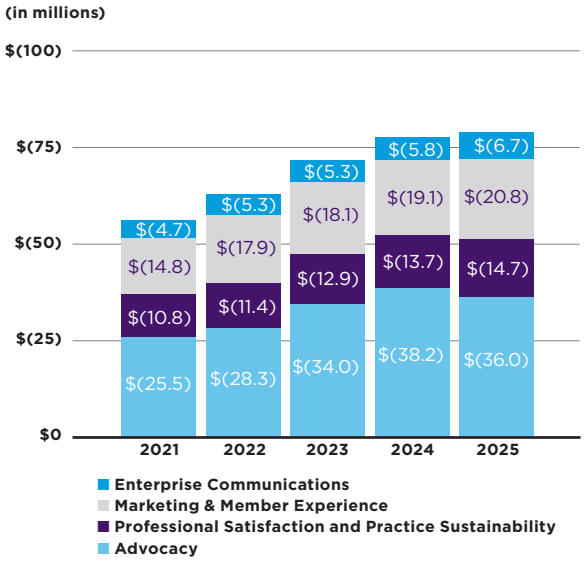
Investments' revenue was $26.7 million in 2025, a $3.8 million increase over the prior year. Dividend and interest income continued to improve in 2025, impacted in large part by an increased level of investible funds. The contribution margin increased by $3.9 million as expenses dropped slightly.

The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2025, AMA reported a net gain of $113.8 million. The total investment return, including investment income, on the reserve portfolios was 11.5 percent compared to a 15.7 percent gain in the composite benchmark index. A combination of factors caused the below benchmark performance including poor performance by a small cap manager that has been replaced and overall private equity market performance that substantially lagged the public market indices in the past year.

Net expenses

Core Mission Activities



Core Mission Activities include direct costs associated with the groups for Advocacy; Professional Satisfaction and Practice Sustainability (PS2); Marketing & Member Experience (MMX); Enterprise Communications, Medical Education (Med Ed); the AMA Ed Hub™; the Center for Optimal Health Outcomes (COHO), previously the Center for Health Equity; Health, Science & Ethics; and Improving Health Outcomes (IHO). The Integrated Health Model Initiative, focused on technology innovation, was closed in 2023. IHO activities have been folded into COHO, fully effective in 2026, to take advantage of synergies between the units. See the chart below for additional business unit results.

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. This ensures that AMA's critical voice is represented in federal and state courts around the country on a broad range of issues, working with state and federal policymakers to oppose legislation and laws that interfere with the practice of medicine and elevating the voice of physician leadership on critical issues of public health.

In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C., and across the country—because physicians play a leading role in shaping the future of health care. At the national level, the AMA continued its critical work to push for Medicare payment reform, fix prior authorization, promote physician-led care and more.

AMA's Fix Medicare Now grassroots campaign and sustained advocacy led to more than 600,000 physicians and patients contacting legislators about Medicare payment reform. While AMA sought a permanent payment increase, the One Big Beautiful Bill Act included a 2.5 percent increase for 2026.

AMA secured a commitment from American's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association to lessen the burden of prior authorization in 60 of their member plans and in partnership with state specialty societies supported passage of more than 20 state laws that reduce care delays caused by prior authorization.

AMA efforts in protecting patients from inappropriate scope of practice expansions, included opposing legislation that would expand pharmacists' scope of practice with respect to testing and treating patients for influenza, COVID-19, RSV and strep throat and, with constituent societies, blocked nearly 100 bills that would have inappropriately expanded the scope of practice for physician assistants, pharmacists, optometrists and more. The AMA had a major win when the National Council of Insurance Legislators adopted model legislation based in large part on AMA's state model bill.

In 2025, Advocacy net spending decreased $2.2 million, due to the absence of a prior year increase in media and professional service costs for the Medicare reform campaign. As noted in AMA's annual budget, the use of these campaign funds would be dependent on the environment. The focus in 2026 is to expand AMA's advocacy efforts such as expanding the Scope of Practice grants to $1 million and increasing spending on a public-facing Medicare payment reform campaign.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction. The work of the digital health unit will transfer to the newly created Center for Digital Health and AI in 2026.

In 2025, the PS2 resources such as the Joy in Medicine™ Health System Recognition Program, the Organizational Biopsy®, STEPS Forward®, webinars, podcasts, coaching and learning collaboratives increased the impact of PS2 efforts with physicians as measured by the number of physicians served and the assessment of high value reflected in post-engagement surveys.

The AMA Joy in Medicine Health System Recognition Program received a record number of applications in 2025 and recognized 109 health systems who met the evidence-based criteria, representing their commitment to organizational well-being. The Organizational Biopsy team partnered with 151 health care organizations to conduct well-being assessments in 2025. AMA STEPS Forward expanded its library and grew webinar attendees and podcast downloads substantially in 2025. AMA also co-sponsored the 2025 American Conference on Physician Health™ with the Mayo Clinic and Stanford Medicine, with a record number of attendees presenting a record high number of abstracts. In 2025, net expenses

increased $1 million, driven almost entirely by staffing increases.

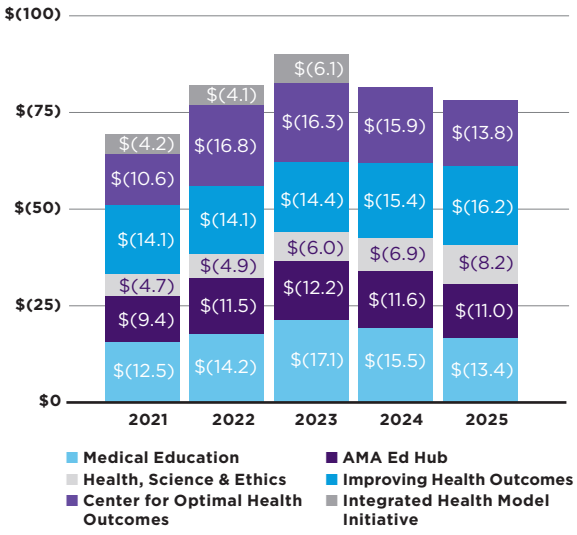
MMX extends the reach and impact of AMA's mission and advocacy initiatives, builds and executes programs to grow and retain members and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement, and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. Key results in 2025 included the continuation of the "Why We Fight" campaign focused on reforming Medicare payment, fighting scope creep, fixing prior authorization, reducing physician burnout, and making technology work for physicians. MMX also focused on working collaboratively with key business units (PS2, IHO, COHO, Med Ed, Ed Hub) to expand delivery of mission value to existing and potential new health system partners and developing a pragmatic and growth-oriented marketing program for AMA's health equity work. AMA's audience of readers, watchers and listeners totaled over 31 million in 2025.

Net expenses increased $1.7 million in 2025, with increased spending on compensation and marketing and promotion to support delivery of AMA's message.

Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care, driving thought leadership on priority issues in health care and digital health; securing speaking opportunities at marquee, high visibility events; publishing op-eds; and enhancing AMA visibility with national and social media opportunities. Net expenses were up $0.9 million in 2025, largely due to increased staffing costs and leveraging outside agency expertise to drive efficient and effective impact across all external channels.

Core Mission Activities (continued)

(in millions)



While the Accelerating Change in Medical Education (ACE) undergraduate medical school grants successfully concluded in 2018 and the five-year Reimagining Residency grants, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work, ended in 2024, AMA has continued to catalyze innovation in medical education through its ChangeMedEd® initiative. Building upon the learning and momentum gained from the two previous programs, the American Medical Association's efforts and focus have entered an important new phase, forming groundwork teams, issuing innovation grants and identifying select innovation sites to tackle the AMA's new priorities in competency-based medical education, precision education and workforce development.

This initiative has inspired a community of innovation in medical education that works collaboratively to create a workforce better prepared to meet the needs of patients and communities, driving change to reduce barriers to lifelong learning, advance health equity and improve patient outcomes. One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2025, Med Ed expanded its efforts on precision education, a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development. The AMA Transforming Lifelong Learning Through Precision Education (Precision Ed) portfolio, launched in 2025, will cultivate and promote democratization of the precision education ecosystem to offer individualized learning that aligns physician education with the needs of patients both now and in the future. The recipients of a four-year, $12 million Precision Education grant program were announced, and 11 teams were identified to receive these grants and join the ChangeMedEd Consortium. Med Ed is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Over 600 attendees took part in the flagship biennial conference, ChangeMedEd 2025, featuring 30 "blue sky" ideas on the application of AI in medical education.

Net expenses decreased $2.1 million in 2025, reflecting the end of the Reimagining Residency grant program in mid-2024. The Precision Ed grants will begin in 2026.

The AMA Ed Hub, formally launched in 2018, is a multi-sided platform providing physicians and other health care providers content and educational services that support lifelong professional development. The Ed Hub has unified the AMA education portfolio and integrated an increasing number of external content providers, launched new content sets, and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives physicians and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. In 2025, the AMA Ed Hub offered more than 9,000 education activities from AMA and over 80 partner organizations. A new Physician Education Program™ was developed in 2025 for physician members, curating member-only educational bundles. Net expenses were down $0.6 million in 2025 due largely to a reduced level of technology development and professional services as the Ed Hub platform has reached a stable state.

The Center for Health Equity (CHE) was created in response to a Board sponsored 2018 taskforce that identified a continuing and urgent need for the AMA to play a leading and public role in eliminating health care disparities and promoting health equity through all segments of our society. In late 2025, certain activities in IHO were sunsetted and others merged with CHE in this newly constituted business unit, renamed the Center for Optimal Health Outcomes (COHO), that will fully support the original goal to achieve optimal health for all by eliminating health inequities and improve health outcomes, particularly for marginalized and underrepresented communities.

During 2025, CHE graduated the third cohort of the Medical Justice and Advocacy Fellowship with fellows presenting their capstone projects at the AMA Interim Meeting; convened the first hybrid meeting of the AMA's Disability Advisory Group and published the first educational module on improving disability inclusion in medicine and health care; and engaged with new policy audiences utilizing the Release the Pressure campaign as an entry point for discussions with lawmakers, engaging for the first time with the Congressional Black Caucus Foundation Annual Legislative Conference. CHE also continued its educational work and continued as an anchor partner in the West Side United Collaborative focusing on improving housing, job creation and local purchasing on Chicago's West Side.

Additionally, CHE and IHO began the transition to the new combined operating unit launching an innovative grant program for physician led community health projects, the Community Health Impact Lab (CHIL) micro grants. COHO (previously CHE) reported a $2.1 million net expense decline in 2025, due mainly to reduced use of outside professional services and a small decline in compensation due to open positions.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates; providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the *AMA Journal of Ethics*®, AMA's online ethics journal, which was wound down in 2025; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in group operating results).

In 2025, this group collaborated with Health AI Partnership and the Duke Institute for Health Innovation to develop physician education on the ethical use of AI, including publishing an ethics AI toolkit on the AMA Ed Hub; launched a new online portal to streamline and improve the application process for generic drug names; supported the Firearm Injury Prevention Task Force; and in collaboration with the Ad Council and a coalition of health care leaders, launched a new digital resource hub to empower physicians and other health care professionals to engage in conversations about firearm injury prevention. Net expenses increased $1.3 million in 2025, with increased staffing costs, a substantial marketing outlay to support flu vaccines and a write-off of technology assets related to closing the *AMA Journal of Ethics*.

As noted above, IHO was downsized substantially in late 2025, with certain activities sunsetted and others merged with the Center for Health Equity in the newly constituted business unit, COHO. IHO over the past several years developed empirically validated tools such as its AMA MAP™ Solutions (for hypertension control) and dashboards that, in conjunction with its well-established partnerships with the American Heart Association (AHA), Centers for Disease Control and Prevention (CDC), and the Ad Council, have created opportunities to focus on community health, in conjunction with the previously named Center for Health Equity.

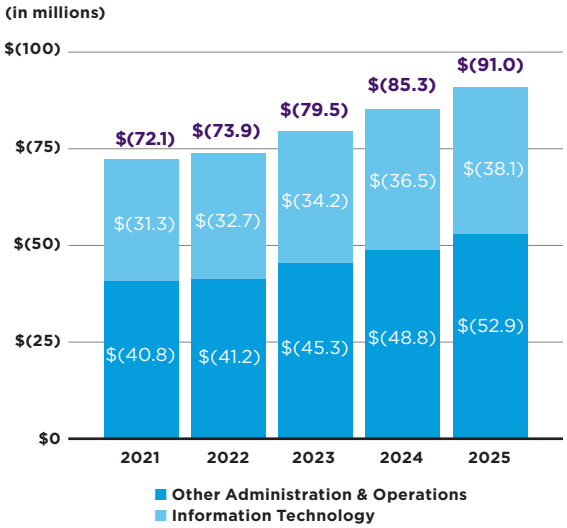
The main focus during most of 2025 was on hypertension outcome goals using cloud-based MAP BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race and gender. The AMA and AHA recognized nearly 2,400 organizations that committed to improving blood pressure control rates by submitting data to the 2025 Target: BP Award Achievement. Over 38 million patients were served by 2,393 total eligible participating health care organizations across 49 U.S. states and territories. To advance the national Million Hearts® campaign, the AMA, in partnership with the CDC and AllianceChicago, engaged five Health Center Controlled Networks and 19 community health centers with an aim to prevent heart attacks and strokes in over 900,000 adult patients, with a focus on minority, rural and medically under-resourced communities.

In 2025, net expenses increased by $0.8 million, largely due to costs related to downsizing certain activities.

Governance

Governance includes the Board of Trustees and Officer Services (BOT), the House of Delegates (HOD) and Sections & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Core Mission Activities. The HOD, Sections & International unit includes costs associated with annual and interim meetings, groups, sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2025, Governance net spending was up $1.2 million, driven by costs for the new Emergency Assistance Program that provides grants to federation societies to fund certain delegate travel costs and higher overall travel and meeting costs for the BOT, HOD and Sections.

Administration and Operations



These units provide administrative and operational support for Publishing & Health Solutions, Membership, and Core Mission Activities, as well as other operating groups. Net expenses were up 6.7 percent in 2025, an increase of $5.7 million, due primarily to compensation costs from staff additions, filling open positions and merit increases; increased technology costs and outside legal fees.

Affiliated Organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2025.

Unallocated Overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2025, these expenses total $28.1 million, down $7.5 million from 2024. Lower incentive and other compensation savings were the main factors in the decline, as well as savings from rent abatement obtained in the headquarters lease renegotiation.

Health2047 and Subsidiary

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop, and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The AMA Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years. These liquidity events generally occur somewhere between eight and twelve years after the initial spinoff.

Health2047's mission is to advance the AMA's core mission by developing early-stage companies that will attract third party investment as they mature to successful financial exits. Health2047 operates with two critical venture industry expectations: one that only a minority of early-stage start-up companies will reach maturity and consequently that it is important to aggressively manage investments and second that the industry expected timeframe for successful exit is between eight and twelve years.

To date thirteen spinout companies have been launched, nine of which continue to operate and are attracting outside interest and investment. Given the relative youth of Health2047, none of these spinout companies have yet achieved a final financial exit. The nine spinout companies reflect a wide range of physician centric solutions including Medicare Advantage for underserved populations, effective data extraction for health care enterprises, obesity phenotyping for precision medicine, cybersecurity situational awareness for health care, evidence-based point of care insight, a digital learning platform for medical and health professional schools, clinical-grade cognitive rehabilitation using AI-powered tools, and augmented intelligence applied to medical images.

Net expenses increased by $2.9 million in 2025, including the impact of a $4.5 million loss on the divestment of ownership in one company, partially offset by reduced use of consultants. In addition, Health2047 liquidated its investment in a subsidiary during 2025, recognizing a $2 million non-operating gain.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues 2025	Revenues 2024	Margin (Net expenses) 2025	Margin (Net expenses) 2024
Membership	**$ 33.0**	$ 32.5	**$ 10.3**	$ 10.5
Publishing, Health Solutions & Insurance				
Publishing	**64.2**	61.7	**0.4**	0.1
Books and Digital Content	**296.4**	280.5	**267.5**	251.1
Database Products	**68.6**	68.2	**51.4**	52.6
Insurance Agency/Affinity Products	**33.5**	34.4	**13.3**	13.8
Other business operations	**-**	-	**(4.3)**	(3.6)
	462.7	444.8	**328.3**	314.0
Investments (AMA-only)	**26.7**	22.9	**25.9**	22.0
Core Mission Activities				
Advocacy	**1.2**	0.9	**(36.0)**	(38.2)
Professional Satisfaction and Practice Sustainability	**0.7**	-	**(14.7)**	(13.7)
Marketing and Member Experience	**0.8**	0.9	**(20.8)**	(19.1)
Enterprise Communications	**-**	-	**(6.7)**	(5.8)
Medical Education	**0.4**	0.2	**(13.4)**	(15.5)
AMA Ed Hub	**0.4**	0.4	**(11.0)**	(11.6)
Health, Science & Ethics	**-**	-	**(8.2)**	(6.9)
Center for Optimal Health Outcomes (Center for Health Equity)	**0.1**	0.7	**(13.8)**	(15.9)
Improving Health Outcomes	**-**	-	**(16.2)**	(15.4)
United States Adopted Names Program	**5.1**	4.7	**4.2**	3.8
Grants	**3.5**	2.9	**0.2**	0.2
	12.2	10.7	**(136.4)**	(138.1)
Governance				
Board of Trustees and Officer Services	**-**	-	**(7.6)**	(7.8)
House of Delegates, Sections, & International	**0.1**	0.1	**(12.5)**	(11.1)
	0.1	0.1	**(20.1)**	(18.9)
Administration and Operations				
Information Technology	**-**	-	**(38.1)**	(36.5)
Senior Executive Management	**-**	-	**(9.4)**	(7.4)
General Counsel	**-**	-	**(8.2)**	(6.6)
Finance & Risk Management	**-**	-	**(10.3)**	(9.8)
Human Resources	**-**	-	**(9.3)**	(8.9)
Corporate Services	**-**	-	**(6.6)**	(6.2)
Customer Service	**-**	-	**(3.9)**	(3.7)
Strategic Insights and Planning	**-**	-	**(5.2)**	(6.2)
	-	-	**(91.0)**	(85.3)
Affiliated Organizations	**0.2**	0.1	**-**	-
Unallocated Overhead	**1.5**	2.1	**(28.1)**	(35.6)
Health2047 & Subsidiary	**-**	-	**(16.3)**	(13.4)
Consolidated revenue and income before tax	**$ 536.4**	$ 513.2	**72.6**	55.2
Income taxes			**(3.9)**	(4.1)
Consolidated net operating income			**$ 68.7**	$ 51.1

CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF ACTIVITIES

Years Ended December 31

(in millions)	2025	2024
Revenues		
Membership dues	$ 33.0	$ 32.5
Advertising	8.2	7.8
Journal print subscription revenues	1.9	2.2
Journal online revenues	32.8	32.2
Other publishing revenues	20.2	18.8
Books, newsletters and online product sales	23.7	22.1
Royalties and credentialing products	340.9	326.0
Insurance commissions	29.0	29.7
Investment income (Note 4)	28.7	25.7
Equity in losses of affiliates (Note 2)	(0.4)	(0.5)
Grants and other income	18.4	16.7
Total revenues	**536.4**	**513.2**
Expenses		
Cost of products sold and selling expenses	17.4	23.7
Contribution to general and administrative expenses	**519.0**	**489.5**
General and administrative expenses		
Compensation and benefits	287.8	279.4
Occupancy	17.5	19.8
Travel and meetings	22.9	20.4
Technology costs	34.7	34.4
Marketing and promotion	21.6	24.1
Professional services	37.1	35.2
Other operating expenses	24.8	21.0
Total general and administrative expenses	**446.4**	**434.3**
Operating results before income taxes	72.6	55.2
Income taxes (Note 10)	3.9	4.1
Net operating results	**68.7**	**51.1**
Non-operating items		
Net gain on investments (Note 4)	113.8	79.7
Defined benefit postretirement plan non-service periodic expense (Note 9)	(6.1)	(5.7)
Other non-operating income	2.1	0.1
Total non-operating items	**109.8**	**74.1**
Revenues in excess of expenses	**178.5**	**125.2**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 9 and 10)	(11.4)	2.0
Change in association equity	**167.1**	**127.2**
Change in donor restricted association equity		
Restricted contributions	0.7	0.7
Net assets released from restriction	(0.8)	(0.6)
Change in association equity – donor restricted	**(0.1)**	**0.1**
Change in total association equity	**167.0**	**127.3**
Total association equity at beginning of year	1,150.7	1,023.4
Total association equity at end of year	**$ 1,317.7**	**$ 1,150.7**

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

As of December 31

(in millions)	2025	2024
Assets		
Cash, cash equivalents and donor-restricted cash	$ 46.4	$ 39.6
Fiduciary funds (Note 2)	22.5	21.6
Investments in affiliates (Note 2)	17.8	19.4
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.1 in 2025 and 2024	118.5	110.2
Inventories	1.5	1.7
Prepaid expenses and deposits	13.2	11.6
Deferred income taxes (Note 10)	4.2	3.5
Investments (Note 4)	1,371.0	1,208.4
Property and equipment, net (Note 7)	20.5	24.7
Operating lease right-of-use assets (Note 11)	41.0	50.2
Other assets (Note 6)	12.6	11.3
	$ 1,669.2	$ 1,502.2
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 16.3	$ 18.8
Accrued payroll and employee benefits (Note 8)	62.6	63.9
Accrued postretirement health care benefits (Note 9)	124.0	108.8
Insurance premiums and other fiduciary funds payable (Note 2)	22.4	21.5
Operating lease liability (Note 11)	56.5	67.4
	281.8	280.4
Deferred revenue		
Membership dues	11.0	11.5
Subscriptions, licensing, insurance commissions and royalties	55.9	56.6
Grants and other	2.8	3.0
	69.7	71.1
Association equity	1,317.7	1,150.6
Donor-restricted association equity	-	0.1
Total association equity	1,317.7	1,150.7
	$ 1,669.2	$ 1,502.2

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended December 31

(in millions)	2025	2024
Cash flows from operating activities		
Change in total association equity	$ 167.0	$ 127.3
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	9.4	10.0
Postretirement health care expense	6.4	6.2
Noncash operating lease expense	9.1	8.9
Net gain on investments	(113.8)	(79.7)
Equity in losses of affiliates	0.4	0.5
Noncash charge (credit) for changes in defined benefit plans other than periodic expense net of tax	11.4	(2.0)
Noncash loss upon liquidation of affiliate and subsidiary	2.4	-
Loss on disposal of property and equipment	0.4	-
Bad debt expense	-	0.1
Other	-	(0.3)
Changes in assets and liabilities		
Accounts receivable and other receivables	(8.3)	(5.8)
Inventories	0.2	0.4
Prepaid expenses and deposits	(1.6)	(1.1)
Accounts payable, accrued liabilities and income taxes	(12.3)	(2.0)
Accrued postretirement benefit costs	(3.2)	(3.0)
Deferred revenue	(1.4)	(5.1)
Net cash provided by operating activities	66.1	54.4
Cash flows from investing activities		
Purchase of property and equipment	(7.4)	(6.4)
Investment in affiliates	(3.1)	(4.2)
Purchase of investments	(1,343.4)	(1,228.6)
Proceeds from sale of investments	1,294.6	1,188.3
Net cash used in investing activities	(59.3)	(50.9)
Net change in cash, cash equivalents and donor restricted cash	**6.8**	**3.5**
Cash, cash equivalents and donor restricted cash at beginning of year	39.6	36.1
Cash, cash equivalents and donor restricted cash at end of year	**$ 46.4**	**$ 39.6**
Noncash operating activities		
Right-of-use assets obtained for lease obligation	$ 0.5	$ 3.1
Noncash investing activities		
Accounts payable for property and equipment additions	$ 0.5	$ 2.3

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

For the Years Ended December 31, 2025 and 2024
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 322 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for a scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company (AMACO) and Health2047 Inc. (collectively, the AMA).

AMACO, a reinsurer for physician medical professional liability coverage, ceased accepting new and renewal business in 1986 and began running off claims under existing contracts. Since 1986, AMACO pursued the commutation of various treaties and the final treaties were commuted in 2024, with all related exposures eliminated. AMACO obtained approval from the Illinois Insurance Commissioner for a plan of dissolution and implemented that plan in 2024, with no material impact on the consolidated financial results.

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2025.

Health2047 controlled and consolidated the results of one company, First Mile Care, Inc., that was liquidated in 2025 resulting in recognizing a $2 million gain that is included in other non-operating income.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The results of one company, Heal Security, Inc. (formed in February 2021) are accounted for under the equity method. At December 31, 2025, AMA ownership interest is 33.3% in Heal Security, Inc. and the book value of the investment, net of convertible debt, is $0.7 million.

In addition, at December 31, 2025, AMA has an ownership interest in eight companies or limited partnerships. The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. This includes ownership interests of 2.7% in Zing Health Enterprises, LP (formed in May 2020), 16.3% in Medcurio Inc. (formed in February 2020), 19.2% in Phenomix Sciences, Inc. (formed in August 2020), 13.6% in Evidium, Inc. (formerly Recovery Exploration Technologies, Inc., formed in August 2021), 5% in Sitebridge Research, Inc. (formed in January 2021), 5.7% in Scholar Rx, Inc. (acquired in December 2022), 5.3% in IntellixAI, Inc. (acquired in 2023), and 3.5% in Cognitive Health Solutions, Inc. (acquired in 2025). The book value of the eight investments carried at cost at December 31, 2025 is $17.1 million. AMA divested the majority of its interest in SiteBridge Research, Inc. during 2025 and recognized a $4.5 million loss that is included in other operating expenses.

Health2047 had investments in nine companies or limited partnerships as of December 31, 2024. Health2047 controlled and consolidated the results of one company, First Mile Care. Inc.

At December 31, 2024, AMA ownership interest was 33.3% in Heal Security, Inc. and the book value of the investment, net of convertible debt, was $1 million.

In addition, at December 31, 2024, AMA had ownership interest of 2.9% in Zing Health Enterprises, LP, 16.4% in Medcurio Inc., 18.7% in Phenomix Sciences, Inc., 13.2% in Evidium, Inc., 18.4% in Sitebridge Research, Inc., 6% in Scholar Rx, Inc. and 5.4% in IntellixAI, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than 20% ownership and did not exercise significant influence over the entities. The book value of the seven investments carried at cost at December 31, 2024 was $18.4 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.4 million held at December 31, 2025 and December 31, 2024.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Furniture and office equipment, hardware and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $111.9 million and $103.8 million as of December 31, 2025 and December 31, 2024, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues by members are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes. See Note 10.

Changes in presentation

In 2025, AMA realigned its business units to reflect the current operations of the organization. As a result, the presentation of the functional expenses for 2024 in Note 15 has been updated to be consistent with the current presentation.

As of December 31, 2025, AMA expanded the disclosure of initial health care cost trend rates. As a result, the presentation of the initial health care cost trend rates for 2024 in Note 9 has been updated to be consistent with the current presentation.

3. New accounting standards update

In December 2023, Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2023-09, *Improvements to Income Tax Disclosures*. This requires an entity to report the amount of income taxes paid disaggregated by federal, state, and foreign taxes as well as the amount of income taxes paid disaggregated by individual jurisdictions in which income taxes paid is equal to or greater than five percent of total income taxes paid. The new standard is effective for AMA for annual periods beginning after December 15, 2025. The adoption of the standard will expand certain footnote disclosures but will not have an impact on the AMA's consolidated financial statements.

In September 2025, FASB issued ASU No. 2025-06, *Targeted Improvements to the Accounting for Internal-Use Software*. This applies to internal use software and replaces the current criteria for capitalization of software development costs with a framework that includes two criteria relating to management authorizing a commitment of funds

and meeting a probable to complete threshold. The new standard is effective for AMA for annual periods beginning after December 15, 2027. The adoption of the standard will not have a material impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as an investment in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment managers. Unfunded commitments as of December 31, 2025, and December 31, 2024 totaled $77.5 million and $76.1 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2025	2024
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 694.2	$ 588.1
Fixed-income mutual funds	20.6	13.8
	714.8	601.9
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	152.1	139.2
U.S. government and federal agency	286.4	275.9
Foreign government	47.9	39.4
U.S. state government	0.2	0.1
	486.6	454.6
Other investments measured at NAV – Private equity and venture capital funds	169.6	151.9
Investments	$ 1,371.0	$1,208.4

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2025	2024
Investment dividend and interest income	$ 33.5	$ 30.1
Management fees	(4.8)	(4.4)
	$ 28.7	$ 25.7

Investment non-operating items include:

	2025	2024
Realized gains on investments, net	$ 55.8	$ 69.8
Unrealized gains on investments, net	58.0	9.9
	$ 113.8	$ 79.7

5. Derivative instruments

AMA uses exchange-traded U.S. Treasury note future contracts in order to efficiently manage duration of fixed income investments in the portfolio. These transactions do not qualify for hedge accounting. The fair value of the futures contracts is recognized as part of investments in the consolidated statements of financial position and changes in the fair value of these futures contracts are recognized as a component of net gain or loss on investments included in non-operating items in the consolidated statements of activities. The fair values as of December 31, 2025 and December 31, 2024 and changes in fair value during 2025 and 2024 were not material.

6. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various non-qualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $12.6 million and $11.3 million as of December 31, 2025 and December 31, 2024, respectively.

7. Property and equipment

Property and equipment at December 31 consists of:

	2025	2024
Leasehold improvements	$ 36.3	$ 36.1
Furniture and office equipment	17.7	17.6
Information technology		
Hardware	12.2	11.4
Software	97.4	100.9
	163.6	166.0
Accumulated depreciation and amortization	(143.1)	(141.3)
Property and equipment, net	$ 20.5	$ 24.7

8. Retirement savings plan

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $10.3 million and $9.8 million in 2025 and 2024, respectively.

9. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2025	2024
Benefit obligation at beginning of year	$ 108.8	$ 107.8
Service cost	0.3	0.5
Interest cost	6.1	5.5
Benefits paid	(4.6)	(4.4)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial loss (gain)	12.0	(2.0)
Accrued postretirement benefit costs	$ 124.0	$ 108.8

The postretirement health care plan accumulated actuarial losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge to equity are $18.4 million and $6.4 million at December 31, 2025 and December 31, 2024, respectively.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2025	2024
Discount rate	5.6%	5.7%
Initial health care cost trend		
Pre-Medicare	9.3%	8.4%
Medicare eligible	8.6%	8.6%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2050	2048

The change in the initial health care cost trend in 2025 and claims cost experience were the major driver of the $12 million actuarial loss in 2025. The change in the discount rate from 5.0% at the end of 2023 to 5.7% in 2024, offset by the impact of higher claims cost experience, was the major driver of the $2 million actuarial gain in 2024.

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2025	2024
Service cost	$ 0.3	$ 0.5
Non-service costs		
Interest cost	6.1	5.5
Amortization of actuarial loss	-	0.2
Total non-service costs	6.1	5.7
	$ 6.4	$ 6.2

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2025	2024
Actuarial (loss) gain arising during period	$ (12.0)	$ 2.0
Reclassification adjustment for recognition of actuarial loss	-	0.2
Change in association equity	$ (12.0)	$ 2.2

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2025	2024
Discount rate	5.7%	5.0%
Initial health care cost trend		
Pre-Medicare	7.9%	8.1%
Medicare eligible	8.1%	8.2%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2026	$ 4.5
2027	5.0
2028	5.4
2029	5.8
2030	6.3
2031–2035	37.3

10. Income taxes

The provision for income taxes includes:

	2025	2024
Operating		
Current	$ 4.0	$ 4.8
Deferred	(6.5)	(5.2)
Valuation allowance	6.4	4.5
	3.9	4.1
Tax (benefit) expense related to credits or charges to equity		
Deferred	(0.6)	0.2
	$ 3.3	$ 4.3

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or expense from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The valuation allowance reflects the fact that deferred tax assets include future expected benefits largely related to net operating or capital losses where recoverability will not occur until future taxable income is generated, as well as retiree health care payments that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred income taxes recognized in the consolidated statements of financial position at December 31 include the following deferred tax assets and (liabilities):

	2025	2024
Net operating and capital loss carryforward	$ 37.3	$ 30.6
Benefit plans and compensation	6.7	6.0
Right-of-use assets	(1.4)	(1.9)
Lease liabilities	1.5	2.1
Other	0.3	0.5
	44.4	37.3
Valuation allowance	(40.2)	(33.8)
	$ 4.2	$ 3.5

Cash payments for income taxes were $3.7 million and $4.3 million in 2025 and 2024, respectively, net of refunds.

AMA's federal taxes are open to examination by taxing authorities from 2022 through 2025. AMA's state taxes are open to examination for various years depending on the jurisdiction.

11. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from four years to 15 years. Most office space leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate or contract with appropriate notice and termination payments. As any renewal, termination, or contraction is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use asset (ROU asset) or lease liability. AMA also leases copiers and printers in several locations, with initial terms generally of four years.

The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All leases are classified as operating leases.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

During 2025, AMA exercised an early termination option in the existing Washington, D.C. office. The ROU asset and lease liability were remeasured as of the modification date resulting in a $4.9 million decrease in both the ROU asset and corresponding lease liability. AMA then entered into a new lease agreement at a different Washington, D.C. location scheduled to commence in 2026. In addition, AMA entered into a new satellite office space lease which resulted in a $0.5 million increase in the ROU asset and corresponding lease liability.

During 2024, AMA entered into a new office space lease which resulted in a $3.1 million increase in the ROU asset and corresponding lease liability.

Operating lease costs totaled $9.1 million in 2025 and $8.9 million in 2024. Cash paid for amounts included in the measurement of lease liabilities totaled $9 million in 2025 and $11.5 million in 2024.

The remaining weighted-average lease term is 9.1 years and 9.9 years as of December 31, 2025 and December 31, 2024, respectively. The weighted-average discount rate used for operating leases is 7.1% and 6.9% for 2025 and 2024, respectively.

The maturity of lease liabilities as of December 31, 2025:

2026	$	4.0
2027		0.9
2028		4.5
2029		11.2
2030		10.7
2031 and beyond		53.7
Total lease payments		85.0
Less imputed interest		(28.5)
Present value of lease obligations	$	56.5

12. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2025	2024
Financial assets	$ 1,417.4	$ 1,248.0
Less assets unavailable for general expenditures:		
Restricted by donor with purpose restrictions	-	(0.1)
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(1,302.8)	(1,132.5)
Financial assets available to meet cash needs for general expenditures within one year	$ 114.6	$ 115.4

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

13. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued. For the year ended December 31, 2025, the AMA has evaluated all subsequent events through February 13, 2026, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

15. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Membership; Publishing, Health Solutions and Insurance; Core Mission Activities and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiary	Total
Cost of products sold and selling expense	$ -	$ 17.4	$ -	$ -	$ -	$ -	$ 17.4
Compensation and benefits	7.9	77.3	-	91.7	103.5	7.4	287.8
Occupancy	0.6	5.1	-	6.6	4.2	1.0	17.5
Travel and meetings	0.2	4.2	-	9.1	8.9	0.5	22.9
Technology costs	1.1	12.9	-	6.9	13.7	0.1	34.7
Marketing and promotion	11.0	1.0	-	9.3	-	0.3	21.6
Professional services	0.4	11.2	0.2	17.0	6.0	2.3	37.1
Other operating expense	1.5	5.3	0.6	8.0	4.7	4.7	24.8
2025 total expense	**$ 22.7**	**$ 134.4**	**$ 0.8**	**$ 148.6**	**$ 141.0**	**$ 16.3**	**$ 463.8**

Cost of products sold and selling expense	$ -	$ 23.7	$ -	$ -	$ -	$ -	$ 23.7
Compensation and benefits	7.4	72.5	-	86.4	105.4	7.7	279.4
Occupancy	0.6	5.5	-	6.8	6.1	0.8	19.8
Travel and meetings	0.1	3.9	-	7.5	8.5	0.4	20.4
Technology costs	1.1	12.5	-	7.4	13.2	0.2	34.4
Marketing and promotion	11.5	0.9	-	11.5	-	0.2	24.1
Professional services	0.4	6.5	0.2	19.4	5.1	3.6	35.2
Other operating expense	0.9	5.3	0.7	9.8	3.8	0.5	21.0
2024 total expense	**$ 22.0**	**$ 130.8**	**$ 0.9**	**$ 148.8**	**$ 142.1**	**$ 13.4**	**$ 458.0**

INDEPENDENT AUDITOR'S REPORT

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2025 and 2024, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of

expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP

February 13, 2026

WRITTEN STATEMENT OF CERTIFICATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2025 and 2024 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

John Whyte MD, MPH
Executive Vice President
and Chief Executive Officer

Denise M. Hagerty
Senior Vice President
and Chief Financial Officer

February 13, 2026

OFFICERS AND TRUSTEES



Standing committees

Executive Committee

Dr. Aizuss, Chair
Dr. Ajayi
Dr. Mukkamala
Dr. Underwood
Dr. Scott
Dr. Ding
Dr. Egbert
Dr. Suk

Audit Committee

Dr. Levin, Chair
Ms. Breig
Dr. Egbert
Dr. Ding
Dr. Ferguson
Dr. Huynh
Dr. Underwood

Awards and Nominations

Dr. Armstrong, Chair
Dr. Garretson
Dr. Jeffers
Mr. Magrath
Dr. Rege
Dr. Van Beek
Dr. Welsh



Compensation Committee

Dr. Suk, Chair
Dr. Aizuss
Dr. Underwood
Dr. Ferguson
Dr. Ajayi
Dr. Scott
Dr. Mukkamala

Governance and Self-Assessment Committee

Dr. Scott, Chair
Dr. Aizuss
Dr. Armstrong
Dr. Ferguson
Dr. Levin
Dr. Suk

Finance Committee

Dr. Ferguson, Chair
Dr. Ding
Dr. Fryhofer
Dr. Heine
Dr. Jeffers
Dr. Underwood
Dr. Suk

Note: Drs. Aizuss, Ajayi and Suk serve on all committees, except where otherwise noted, as ex-officio *members without vote. Dr. Mukkamala serves on all committees as an* ex-officio *member with vote.*

REPORT OF THE BOARD OF TRUSTEES

BOT Report 04-A-26

Subject: AMA 2027 Dues

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee F

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

RECOMMENDATION

2027 Membership Year

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

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

(Directive to Take Action)

Fiscal Note: Minimal

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 34-A-26

Subject: Discontinuation of AMA Citation for Distinguished Service

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee F

The Awards and Nominations Committee of the American Medical Association (AMA) Board of Trustees administers all AMA Awards. In 2025, the Board voted to discontinue the Citation for Distinguished Service, one of only two awards referenced in the Bylaws.

The Citation for Distinguished Service was created in 1948, with the first citation awarded in 1952. The Citation was intended to recognize individuals who were not part of the medical profession but who have "by their cooperation and aid in the advancement of medical science, medical education or medical care contributed to the achievement of the ideals of American medicine." The last AMA Citation for Distinguished Service was awarded in 2009 with no subsequent nominations. Due to the lack of interest, on recommendation of the Awards and Nominations Committee, the Board voted to discontinue the Citation. However, as the Award is referenced in the AMA Bylaws, a bylaw amendment is needed. The Board also wants to apprise the House of its decision and rationale for discontinuing it.

RECOMMENDATION

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

> That the AMA Bylaws be amended to eliminate reference to the Citation for Distinguished Service.

(Modify Bylaws)

Fiscal Note: Less than $500

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REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, A-2026

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Jessica Krant, MD, Chair

Referred to: Reference Committee F

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

METHODOLOGY

The Committee considered elements of Officer compensation that have not been updated recently to reflect increases in costs or changing expectations of specific Board Leadership roles. Two areas were identified for further research and discussion by the Committee: secretarial reimbursement maximums and allowances for airfare upgrades.

To support this review, the Committee recently commissioned Willis Towers Watson (WTW), a major compensation consulting firm with expertise in board compensation, to review the market practices for reimbursement of board members' secretarial expenses. The Committee also reviewed

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historical adjustments to both secretarial reimbursement maximums and travel upgrade allowances and considered any changes to the secretarial needs and travel requirements for Board Leadership.

FINDINGS

Secretarial Expenses

WTW provided updated data regarding market practices for reimbursement of Board members' secretarial expenses from the 2025 PRM Not-for-Profit Survey, indicating the following:

> Secretarial expense reimbursement for Board members in not-for-profit organizations is a minority practice. WTW stated, as previously established, that the time commitment of AMA board members is significantly higher than other not-for-profit boards. Given the work of AMA board members and the time commitment, the secretarial needs of the AMA board members are different than a traditional not-for-profit board, supporting the need for reimbursement of secretarial expenses for AMA board members.
>
> When reimbursement is provided, practices are split between the benefit being capped and uncapped. Uncapped is more common. For example, the benefit is uncapped by 73 percent of organizations for the President and 71 percent of organizations for the President-elect. This represents a higher prevalence than reported in 2024.

The AMA maximum annual secretarial reimbursement is $15,000 for the Board President and $5,000 for the President-Elect, Chair, Chair-Elect, and Immediate Past President. These reimbursement maximums have not been updated since before the HOD Compensation Committee was established in 1999. Effective January 1, 2025, the secretarial reimbursement for all other Officers increased from $750 to $1,125.

The Committee also considered the increasing secretarial needs of the Speaker and Vice Speaker to determine if these positions should be moved to the $5,000 secretarial reimbursement maximum.

Travel Upgrade Allowance

The Committee considered the travel requirements of all Officers. Effective July 1, 2022, the annual travel upgrade allowance for the President, Immediate Past President and President Elect is $5,000 and the upgrade allowance for all other Officers is $2,500. The allowance can be used for airfare upgrades at the discretion of the Officer.

The Committee considered the increased travel requirements and travel costs for all Officers following the most recent increase in 2022 (post-COVID). The Committee also considered the increasing travel requirements of the Board Chair to determine if this position should be moved to the higher travel upgrade allowance for Board Presidents.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following changes to Officer compensation be adopted effective July 1, 2026, and the remainder of this report be filed:

1. That the maximum annual secretarial reimbursement for the Speaker and Vice Speaker is increased from $2,500 to $5,000 to reflect the increasing secretarial needs of these positions.

2. That the maximum annual secretarial reimbursement for non-leadership Officers is increased from $1,125 to $1,200 to reflect a modest cost-of-living adjustment.

3. That the travel upgrade allowance for the Presidents (President, Immediate Past President and President Elect) is increased from $5,000 to $6,000.

4. That the Board Chair is moved to the same travel upgrade allowance as Presidents.

5. That the travel upgrade allowance for all other Officers is increased from $2,500 to $3,000.

6. That the definition of the Secretarial Expenses be revised as follows:

   The AMA will provide a stipend of $15,000 to provide secretarial support at a designated location, other than the AMA, for the President during the Presidential year. Secretarial expenses are paid for the President-Elect, Chair, Chair-Elect, ~~and~~ Immediate Past President, Speaker and Vice Speaker to a maximum of $5,000 per officer. If the officer holds office for only one-half of the calendar year (January-June or June-December), expense reimbursement will be a maximum of $2,500 per officer. Secretarial expenses incurred by other officers in connection with their official duties are paid up to ~~$1125~~ $1,200 per year per general officer.

7. That the definition of Transportation be revised as follows:

   Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) and Chair will each have access to an individual ~~$5,000~~ $6,000 term allowance (July 1 to June 30) and all other Officers will each have access to ~~$2,500~~ an individual $3,000 term allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA.

   In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized, when necessary, by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV—Invitations, B–Foreign, for policy on foreign travel).

8. That the remainder of the report be filed.

   Fiscal Note: $23,350 additional expense on an annual basis

APPENDIX

Board Leadership Compensation

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630
Speaker	$125,000
Vice Speaker	$115,000

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-26)

Introduced by: Pennsylvania, Florida, New York, Texas

Subject: Board Chair Term Limits

Referred to: Reference Committee F

Whereas, the Bylaws of the American Medical Association (AMA) specify that the Chair of the Board of Trustees serves a one-year term, resulting in rapid turnover of board leadership; and

Whereas, leading governance authorities emphasize that effective board leadership requires continuity, stability, and sufficient tenure to oversee long term strategic initiatives; BoardSource recommends multi-year chair terms to preserve institutional memory, and the National Association of Corporate Directors (NACD) similarly advises extended leadership cycles to align governance with organizational strategy; and

Whereas, Dr. Richard LeBlanc, in The Handbook of Board Governance, notes that an adequately tenured board chair is essential for ensuring effective oversight of senior management, maintaining accountability structures, and stewarding long range organizational priorities; and

Whereas, the AMA's strategic initiatives, advocacy agenda, and oversight responsibilities span multiple years, making annual turnover in board leadership potentially disruptive to consistent governance and sustained evaluation of senior management performance; and

Whereas, many national nonprofit and professional associations have adopted longer or renewable board chair terms to strengthen leadership continuity, improve board effectiveness, and enhance oversight of executive performance; therefore be it

RESOLVED, that our American Medical Association commission an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and AMA membership (Directive to Take Action); and be it further

RESOLVED, that our AMA provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the AMA (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership

continuity, including any proposed amendments to the AMA Constitution and Bylaws for consideration by the House of Delegates. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/19/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-26)

Introduced by: Oregon

Subject: Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones

Referred to: Reference Committee F

Whereas, in recent years, there has been a dramatic escalation of violence against healthcare personnel and humanitarian aid workers around the world[1, 11, 12]; and

Whereas we physicians live and work around the works in a global economy, either as volunteers or professionally or both, and many of us have families and roots in places of conflict[13-16]; and

Whereas, International Law as outlined in the updated Geneva Conventions, written as a response to wars in the 1900's, specifically consider attacking hospitals, medical schools, healthcare and humanitarian workers, and patients seeking and receiving treatment illegal and unethical[8, 9]; and

Whereas, according to UN and NGO reports, 2024 was the deadliest year on record, with 383 humanitarian workers killed. Attacks were documented in Gaza Myanmar, Ukraine, Sudan and Syria, where hospitals and clinics have been bombed, medical convoys obstructed, and health care providers detained or executed; and

Whereas in 2025, Médecins Sans Frontières (MSF) reported 1,348 attacks and WHO reported 1366 attacks on health-care facilities, and in 2026 to date, the WHO reports at least 313 attacks in Sudan, Iran, Lebanon, Israel and possibly Afghanistan[10-12]; and

Whereas, the deliberate targeting and obstruction of medical care—is referred to by some ethicists and human rights observers as "medicide"; and

Whereas, attacks on hospitals, forced displacement of populations, and the deliberate prevention of medical supply delivery have become systematic tactics in modern conflicts, in direct violation of International Humanitarian Law[1-12]; and

Whereas, these actions have resulted in catastrophic health outcomes for civilian populations and have undermined the safety and neutrality of medical and humanitarian missions globally; therefore be it

RESOLVED, that our American Medical Association will amend H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict by addition to read as follows:

a. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.

b. Our American Medical Association supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

c. Our American Medical Association condemns the use of all forms of violence, forced displacement, and obstruction of any aid and healthcare in any location against healthcare personnel, humanitarian aid workers, and healthcare institutions.

d. Our American Medical Association advocates for an absolute ban on targeting, detention, or attack of healthcare workers, humanitarian personnel, and their institutions, and demands the immediate release of any healthcare or humanitarian personnel held captive.

e. Our American Medical Association actively opposes the use of force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, whether domestically or internationally.

Fiscal Note: Minimal – less than $5,000

Received: 4/8/26

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RELEVANT AMA POLICY

H-520.985 Protection of Healthcare and Humanitarian Aid Workers

1. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.
2. Our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict. [Res. 603, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-26)

Introduced by: New Jersey

Subject: Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy

Referred to: Reference Committee F

Whereas, medical literacy is essential for patients to make informed decisions about their care and improve health outcomes; and

Whereas, the Journal of the American Medical Association (JAMA) has published “JAMA Patient Pages” for years as a trusted source of accessible, evidence-based medical information for patients and the public; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, existing JAMA Patient Pages represent a substantial, high-quality repository of patient education materials that could be more widely utilized to promote medical literacy; and

Whereas, easily accessible and well-organized patient education materials can support patients in managing their health, understanding treatment options, and fostering effective partnerships with physicians in their care and recovery; and

Whereas, making these patient pages available to the general public in a consolidated, searchable, and freely accessible format would enhance public understanding of medical issues and contribute to health equity by reducing disparities in medical literacy; and

Whereas, our American Medical Association has a long-standing commitment to advancing public health and promoting informed patient decision-making; therefore be it

RESOLVED, that our American Medical Association publized the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (Directive to Take Action); and be it further

RESOLVED, that our AMA shall compile and organize previously published JAMA Patient Pages into a publicly accessible database or repository for the purpose of improving medical literacy and fostering patient-physician partnerships (Directive to Take Action); and be it further

RESOLVED, that our AMA explores opportunities to promote awareness and utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-26)

Introduced by: Michigan

Subject: Annual Scorecard to Evaluate the AMA's Impact

Referred to: Reference Committee F

Whereas, the American Medical Association (AMA) aims to promote the art and science of medicine and the betterment of public health; and

Whereas, it is important for the AMA to continuously evaluate its performance to align with evolving healthcare needs and priorities; and

Whereas, a transparent and systematic approach to measuring effectiveness can enhance trust and accountability among members and stakeholders; and

Whereas, there is a need for accountability and transparency in assessing the AMA's impact and effectiveness in achieving its goals; and

Whereas, a systematic and data-driven approach can provide valuable insights into the AMA's performance and areas for improvement; therefore be it

RESOLVED, that our American Medical Association consider implementing a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics:

1. Medicare Impact: percent change in the Medicare Physician Fee Schedule;
2. Advocacy Impact: number of federal policies successfully influenced or implemented;
3. House of Delegates Impact: number of AMA policies translated into legislation or federal policy;
4. Financial Impact: percentage of revenue dedicated to advocacy; and,
5. Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers (Directive to Take Action); and be it further

RESOLVED, that our AMA shall review metric definitions and targets and provide a report by the 2027 AMA Annual Meeting. Any future updates to metrics or targets shall be recommended via a report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect (Directive to Take Action); and be it further

RESOLVED, that our AMA shall consider publishing the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2028. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/10/26

RELEVANT AMA POLICY

Actions and Decisions by the AMA House and Policy Implementation G-600.071
1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-26)

Introduced by: Michigan

Subject: Review of Past Resolutions

Referred to: Reference Committee F

Whereas, the American Medical Association (AMA) is an organization charged to advocate on behalf of their members; and

Whereas, AMA members rely on the AMA House of Delegates to pass resolutions to that effect, and

Whereas, the AMA Board of Trustees is charged with ensuring these resolutions are implemented; and

Whereas, the AMA has not disseminated a detailed aggregate report to ensure the AMA membership is aware that the work of the House is being accomplished; therefore be it

RESOLVED, that our American Medical Association consider presenting, by the 2027 AMA Annual Meeting, a detailed and aggregate report that is easily accessible and includes the following data for the past 10 years; the total number of resolutions submitted and passed; the number of those resolutions specific to advocacy on the sustainability of medical practices; a breakdown of these resolutions by Annual and Interim meetings; and the percentage of resolutions that have been successfully implemented. The report shall be produced on an annual basis and included in the Annual meeting handbook. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/10/26

RELEVANT AMA POLICY

Actions and Decisions by the AMA House and Policy Implementation G-600.071
1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and

report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-26)

Introduced by: American Society of Plastic Surgeons; American Association for Hand Surgery; American Society for Aesthetic Plastic Surgery; American Society for Maxillofacial Surgeons; American Society for Reconstructive Microsurgery; Michigan State Medical Society; Missouri State Medical Association

Subject: Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees is charged through its duties and privileges to conduct the affairs, work and activities of the AMA and to exercise broad oversight and guidance for the AMA with respect to the management systems of the AMA through its oversight of the AMA's Executive Vice President; and

Whereas, current policy G-600.071 and current practice yield authority to BOT on AMA action in urgent situations, and further allow the BOT to make a determination of what it deems best represent the interests of patients, physicians, and the AMA; and

Whereas, current policy does not yield primary authority to or allow the independent authority to AMA management on AMA action in urgent situations or the determination of what best represents the interests of patients, physicians, and the AMA; and

Whereas, notable major AMA efforts to lobby and negotiate with Congress have resulted in legislative packages that profoundly negatively impacted health system financing and physician reimbursement, [1-9] administrative burden in clinical settings, [1,2] and the widespread loss of coverage for patients; [8,9] and

Whereas, the results of these efforts suggest opportunity to strengthen the processes that underpin the BOT's (1) duty to implement the charges delivered by the House in its capacity as the legislative and policymaking body of the AMA, and (2) duty to oversee AMA management's management and direction of day-to-day duties of the AMA, including advocacy activities; and

Whereas, there is currently no clear AMA policy requiring the BOT to be informed or consulted, let alone appropriately directly involved, in times of direct negotiation with federal policymakers or their representatives on matters that have significant impact on the economic or clinical experience of patients or physicians; therefore be it

RESOLVED, that our American Medical Association amend G.600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read as follows:

8. Our AMA shall develop such processes as the BOT deems appropriate to ensure the BOT is apprised on a weekly basis of AMA activity related to the policy actions and directives adopted by the House of Delegates that occurred through:
    a. the formal meetings and notable informal meetings with stakeholders and policymaking entities;
    b. the formal correspondence, comments, or testimony submitted by the AMA
    c. notable informal correspondence exchanged between AMA management and policymakers or other stakeholders;
    d. the relevant correspondence received from the leadership of entities in organized medicine, the federal government, or any other relevant sector; and
    e. any developments with respect to new or existing policy concepts, policy negotiations, or policy proposals on transformational national health policies.

9. Our AMA BOT will be directly informed and consulted prior to the onset of and throughout the course of any negotiations between AMA management and federal policymakers on transformational changes to national health policies, such as alteration of the methodology for reimbursing physicians under any component of the public sector payer apparatus or the sunsetting or creation of any program that is likely to impact more than half of all Medicare participating providers. (Modify Current HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

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1. American Medical Association, “Joint Letter on MACRA Implementation and the Future of Physician Payment,” PDF letter, May 26, 2021, http://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/2021-5-26-Joint-letter-to-WM-MACRA-Implementation-and-Future-of-Physician-Payment_ACS_ACP_AMA-(1).pdf. Accessed September 29, 2025.
2. American Medical Association, “Letter to Reps. Cathy McMorris Rodgers, H. Morgan Griffith, Frank Pallone Jr., and Kathy Castor Regarding MACRA Hearing,” PDF letter, June 21, 2023, https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfct.zip/2023-6-21-Letter-to-McMorris-Rodgers-Griffith-Pallone-Castor-re-MACRA-Hearing-v3.pdf. Accessed September 29, 2025.
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4. American Medical Association, “AMA Statement on Medicare Cuts,” press release, https://www.ama-assn.org/press-center/ama-press-releases/ama-statement-medicare-cuts. Accessed September 29, 2025.
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7. American Medical Association, “Congress Abandons Medicare Patients and Their Physicians,” press release, https://www.ama-assn.org/press-center/ama-press-releases/congress-abandons-medicare-patients-and-their-physicians. Accessed September 29, 2025
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9. American Medical Association, “Congress Moves Health Care in Wrong Direction,” press release, https://www.ama-assn.org/press-center/ama-press-releases/ama-congress-moves-health-care-wrong-direction. Accessed September 29, 2025.

RELEVANT AMA POLICY

G-600.071 Actions and Decisions by the AMA House and Policy Implementation
1.AMA policy on House actions and decisions includes the following:

a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.

b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.

c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:

a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.

b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.

c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

5. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.

6. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.

7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.
Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input. [Res. 45, I-89Res. 609, I-95Res. 605, I-98Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00 Consolidated: CLRPD Rep. 3, I-01Appended: BOT Rep. 19, A-04Modified: CCB/CLRPD Rep. 1, A-12Appended: Res. 618, A-19Modified: Res. 602, A-25]

HOD C- Article IV
The House of Delegates is the legislative and policymaking body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws. [Last modified 2017]

B-5.3 Duties and Privileges
In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Shortening the AMA House of Delegates Endorsement Process and Timeline

Referred to: Reference Committee F

Whereas, the American Medical Association (AMA) distinguishes between "sponsorship," which is reserved for a candidate's home delegation or section, and "endorsement," which allows other groups to formally signal support for a candidate; and

Whereas, under current rules, groups wishing to endorse must submit their internal processes and criteria nearly two years in advance (e.g., November 2025 for June 2027 elections), creating a significant administrative barrier for both candidates and potential endorsing groups; and

Whereas, many caucuses, delegations, state and specialty societies, and AMA sections currently provide endorsements, yet many other eligible groups abstain due to the long gap between the endorsement window opening and the actual election; and

Whereas, potential endorsing groups have cited the extra work of conducting additional interviews so far in advance and a limited understanding of the tangible benefits of participation as reasons for declining to offer endorsements; and

Whereas, shortening the timeline would align the endorsement process more closely with the active campaign window, thereby increasing the relevance and recollection of endorsements and reducing campaign fatigue for both candidates and groups; therefore be it

RESOLVED, that our American Medical Association amend Policy G-610.090, "AMA Election Rules and Guiding Principles," by addition and deletion, effective immediate to the 2028 election endorsement cycle, to read as follows:

G-610.090 AMA Election Rules and Guiding Principles
...
XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner, no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place.

2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.

3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.

4. Our AMA will create a specific period (similar to virtual elections) during which endorsements

may be sought, with the endorsement window opening at the commencement of the Interim Meeting immediately preceding the Annual Meeting at which the election is to take place. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

RELEVANT AMA POLICY

G-610.090, AMA Election Rules and Guiding Principles
The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

Glossary of Election Terms

Active campaign window – Period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate – Person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) – Person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign presentation – A written or verbal presentation about a campaign or a solicitation of votes for an AMA election to a non-sponsoring group. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind.

Campaign team – Campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related – Any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital – Relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of “Sponsoring Group.”

Endorse - Any public acknowledgement by a candidate or members of a group of the group’s support of a candidate. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured – Identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- Sponsoring group is an endorsing group that may offer endorsements to the delegate(s) and/or alternate delegate(s) representing that sponsoring group without the need to provide their endorsement process to the HOD Office.
- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees or Council members seeking re-election or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election.
- Individuals may self-sponsor (self-nomination).

I. Guiding Principles
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. Our American Medical Association delegates should:
   a. avail themselves of all available background information about candidates for elected positions in our AMA.
   b. determine which candidates are best qualified to help the AMA achieve its mission.
   c. make independent decisions when voting for candidates.
2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members fo our AMA leadership positions.
5. Incumbency should not assure the re-election of an individual to an AMA leadership position.
6. Service in any AMA leadership position should not assure ascendancy to another leadership position.
7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
9. Every state and specialty society delegation is encouraged to participate in a caucus, for the purposes of candidate review activities.

II. Guidelines for Candidacy for AMA Offices

1. Every effort should be made to have two or more candidates for each vacancy.
2. The Federation (in sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, the office sought, the sponsoring group, if any, and a list of endorsing groups, if any. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
2. Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows the April Board meeting.
3. Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on the elected councils or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Candidate Notification. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than on Official Candidate Notifications.
4. The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.
5. If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled positions would remain unfilled until the next annual meeting.
6. Our AMA believes that:
   a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
   b. elected specialty society members should be identified in that capacity while serving their term of office.
   c. nothing in the above recommendations should preclude endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.
7. Our AMA requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election. Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD

Opening Session. The HOD Office will post such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

8. Candidates will be provided with a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all actions or inaction undertaken on their behalf that is campaign related.

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees meeting immediately preceding the meeting at which the election is scheduled to take place.
2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy except in private conversations with the announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.
3. An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.
4. Our AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.
5. An AMA Candidates' Page will be created on our AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.
6. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
7. Active campaigning via mass outreach to delegates by candidates or on behalf of the candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. Electronic messages must include a simple mechanism to allow recipients to opt out of receiving future messages.
8. Printed and digital campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page.
9. Displays of campaign posters, signs, and literature in public areas of the venue at which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.
10. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins

should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

11. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

V. Group Dinners and Meetings

1. Candidates for our AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.
2. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.
3. Each participant in group dinners, if attended by an announced candidate in a currently contested election, must pay their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

1. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.
2. Any formal questioning of an announced candidate, excluding a written questionnaire, is an interview and subject to the rules for interviews.
3. Interviews may be arranged between the parties once active campaigning is allowed.
4. Groups conducting interviews with announced candidates for a given office must offer an interview to all announced candidates at the time the group's interview schedule is finalized.
   a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with other candidates for the same office.
   b. Interviewing groups may, but are not required to, interview persons who become announced candidates during the active campaign window. Should an interview be offered to such a candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
   c. Any campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.
5. Groups may elect to conduct interviews virtually or in-person.
6. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
7. Virtual interviews are subject to the following constraints:
   a. Interviews may be conducted only during a 9-14 day window (preferably across two separate weekends) as designated by the Speaker beginning at least two weeks but not more than six (6) weeks prior to the scheduled Opening Session of the House of Delegates meeting

at which elections will take place.

b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.

c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

8. Recording of interviews is allowed only with the knowledge and consent of the candidate.
9. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
10. Recordings of interviews may be shared only among members of the group conducting the interview.
11. A candidate is free to decline any interview request.
12. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
13. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

VII. Campaign Receptions

1. Our AMA will sponsor the AMA Candidate Reception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate Reception. There will not be a receiving line at the AMA Candidate Reception. The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception will apply to the AMA Candidate Reception.
2. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

VIII. Election Process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.
5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

IX. Election Committee

1. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

X. Campaign Complaint Reporting, Validation and Resolution Process

1. Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
    a. The name of the person(s) thought to have violated the rules
    b. The date of the alleged violation and the location if relevant
    c. The specific violation being alleged (i.e., the way the rules were violated)
    d. The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.
2. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
3. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
    a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
    b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
    c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
    d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
    e. Deliberations of the Election Committee shall be confidential.
    f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.
4. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by our AMA Office of General Counsel and kept confidential.
5. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought. [Speakers Rep. 3, I-23 Modified: Res. 609, A-24 Modified: CCB Rep. 3, A-24 Modified: Speakers Rep. 01, I-24 Modified: Speakers Rep. 02, I-24 Appended: Speakers' Rep. 02, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-26)

Introduced by: American College of Occupational & Environmental Medicine, Iowa, Minnesota, Nebraska, North Dakota, South Dakota, American Academy of Physical Medicine & Rehabilitation, American Academy of Family Physicians

Subject: Reinstitution of AMA Guides Editorial Panel

Referred to: Reference Committee F

Whereas, our AMA established the AMA Guides Editorial Panel in 2019 in order to update the AMA Guides to the Evaluation of Permanent Impairment 6th edition (purple book) published in 2008[1]; and

Whereas, the AMA Guides Editorial Panel consisted of two co-chairs, ten voting members and five advisors, representing vast multispecialty and multidisciplinary perspectives on medical impairment ratings[2]; and

Whereas, the AMA Guides became a digital product to allow continuous and real time updates to the impairment evaluation process in order to bring the best science to establish fair and equitable impairment ratings[3]; and

Whereas, the AMA Guides Editorial Panel instituted updates to the chapters on mental health (2021), nervous system (2023), upper limb, lower limb and spine (2024), and pulmonary (2025) which have received wide support across multiple stakeholder groups[3]; and

Whereas, the goal of the AMA Guides Panel and as originally stated by the AMA was to institute a continuous evidence-based update to all chapters of the AMA Guides to the Evaluation of Permanent Impairment; and

Whereas, the AMA staff decided to discontinue the AMA Guides Editorial Panel at the end of 2025, thus ceasing the originally stated goal of a continuous update process, a decision that was not supported by the co-chairs or panel members; and

Whereas the non-updated chapters including pain, vision, cardiovascular system, digestive system, urinary and reproductive system, skin, hematopoietic system, and endocrine system have not been updated and are using outdated science and information that in many cases is 20-25 years old; and

Whereas, the AMA supports using the best available science and evidence basis for medical assessments; therefore be it

RESOLVED, that our American Medical Association re-institute the AMA Guides Editorial Panel to its original configuration and operating status (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the AMA Guides Editorial Panel to continue its work on updating the chapters of the AMA Guides to the Evaluation of Permanent Impairment 6th edition

2025 that have yet to be addressed and to continue to bring current evidence based medicine and practices to the evaluation of permanent impairment. (Directive to Take Action)

Fiscal Note: Major - $271,952. Annual Editorial Panel funding.

Received: 4/14/26

REFERENCES

1. https://www.ama-assn.org/press-center/ama-press-releases/new-process-takes-ama-guides-future
2. https://www.ama-assn.org/practice-management/ama-guides/ama-guides-editorial-panel-members
3. https://www.ama-assn.org/practice-management/ama-guides/ama-guides-evaluation-permanent-impairment-overview#toc-changes-to-the-ama-guides-editorial-panel-work-07

RELEVANT AMA POLICY

Revising "Guides to the Evaluation of Permanent Impairment" H-365.987
It is the policy of the AMA: (1) to pursue the comprehensive revision and updating of the Guides to the Evaluation of Permanent Impairment with input from physicians in all appropriate specialty groups; and (2) to consider developing appropriate methods to facilitate the use of the Guides, including expansion of introductory instructions.

Physician's Role in Returning Patients to Their Jobs H-365.999
Our AMA:
(1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

(11) encourages physicians to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work.
(12) supports the adoption of the most current edition of the AMA Guides to the Evaluation of Permanent Impairment by all jurisdictions to provide fair and consistent impairment evaluations for patients and claimants including injured workers.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-26)

Introduced by: New York

Subject: American Medical Association Board Chair Term Limits

Referred to: Reference Committee F

Whereas, the Bylaws of the American Medical Association (AMA) specify that the Chair of the Board of Trustees serves a one-year term, resulting in rapid turnover of board leadership; and

Whereas, leading governance authorities emphasize that effective board leadership requires continuity, stability, and sufficient tenure to oversee long-term strategic initiatives; BoardSource recommends multi-year chair terms to preserve institutional memory, and the National Association of Corporate Directors (NACD) similarly advises extended leadership cycles to align governance with organizational strategy; and

Whereas, Dr. Richard LeBlanc, in *The Handbook of Board Governance*, notes that an adequately tenured board chair is essential for ensuring effective oversight of senior management, maintaining accountability structures, and stewarding long-range organizational priorities; and

Whereas, the AMA's strategic initiatives, advocacy agenda, and oversight responsibilities span multiple years, making annual turnover in board leadership potentially disruptive to consistent governance and sustained evaluation of senior management performance; and

Whereas, many national nonprofit and professional associations have adopted longer or renewable board-chair terms to strengthen leadership continuity, improve board effectiveness, and enhance oversight of executive performance; therefore be it

RESOLVED, that our American Medical Association Board of Trustees commission an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations (Directive to Take Action); and be it further

RESOLVED, that this independent assessment examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and American Medical Association membership (Directive to Take Action); and be it further

RESOLVED, that the Board of Trustees provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the American Medical Association (Directive to Take Action); and be it further

RESOLVED, that the Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations

regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the American Medical Association Constitution and Bylaws for consideration by the House of Delegates. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(A-26)

Introduced by: New York

Subject: Plant-Based Diets at AMA meetings

Referred to: Reference Committee F

Whereas, a substantial and growing body of scientific evidence demonstrates that dietary patterns emphasizing plant-based foods are associated with reduced risks of cardiovascular disease, type 2 diabetes, obesity, and certain cancers, as well as lower all-cause mortality; and

Whereas, these benefits are most consistently observed when diets emphasize whole grains, vegetables, fruits, legumes, and nuts, while limiting red and processed meats and ultra-processed foods; and

Whereas, emerging longevity research highlights that individuals who maintain preserved cognitive and physical function into advanced age often share common lifestyle patterns, including plant-forward dietary habits, metabolic health, and lower burden of chronic disease; and

Whereas, the concept of healthy aging emphasizes not merely increased lifespan, but preservation of function, independence, and quality of life, with diet representing a modifiable determinant of long-term physiological resilience; and

Whereas, well-planned plant-forward dietary patterns, including Mediterranean dietary models that incorporate minimal amounts of animal products, are associated with improved cardiometabolic health while supporting nutritional adequacy and sustainable long-term adherence; and

Whereas, dietary patterns higher in plant-based foods are also associated with significant benefits for planetary health, including reductions in greenhouse gas emissions, land use, water consumption, and environmental degradation; and

Whereas, research in behavioral economics demonstrates that small, non-coercive changes in choice architecture, such as increasing the availability and visibility of healthier options, can effectively promote beneficial behaviors while preserving individual autonomy; and

Whereas, the American Medical Association and the Medical Society of the State of New York have long emphasized prevention, population health, and physician leadership by example, and professional meetings provide an opportunity to model dietary patterns that support both healthy aging and sustainability; therefore be it

RESOLVED, that our American Medical Association encourages the use of evidence-based behavioral science strategies, such as choice architecture and nudging, to promote healthier dietary choices at professional gatherings, while respecting individual autonomy (New HOD Policy); and be it further

RESOLVED, that our American Medical Association recognizes the importance of modeling prevention through food choices at its own meetings, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices

Referred to: Reference Committee F

Whereas, medicine is under assault from all sides—from insurance companies to trial lawyers to onerous state and federal regulations; and

Whereas, the 118th United States Congress enacted 209 public laws, which contrasts with approximately 16,000 items of state legislation passed annually[1,2,3]; and

Whereas, we do not have enough physicians in political office on the local, state, or federal levels and in general there may be some benefit to supporting "medicine-friendly" physicians and physician spouses who run for political office; and

Whereas, our medical societies have political action committees, such as AMPAC for the AMA, to support "medicine-friendly" candidates running for office; and

Whereas, AMPAC holds an annual "Candidate Workshop" and "Campaign School" to support "medicine-friendly" candidates running for elected offices[4]; and

Whereas, there are few mechanisms to enable physician members of our state and national medical societies to network when running for state and federal office; and

Whereas, partly due to high educational debt loads, busy clinical schedules, challenges with work-life balance, and limited bandwidth to engage in political activity, physicians have traditionally had a low level of giving to candidates for local, state, and federal offices; and

Whereas, those of us who have more time than money could potentially help candidates for elected office with social media support (retweeting, likes, etc.) and/or volunteer time; and

Whereas, "medicine-friendly" candidates for political office would be interested in meeting potential donors, as well as individuals who may be willing to volunteer to support their campaigns with volunteer time and social media support; and

Whereas, there is currently no "central repository" that lists physicians or physician spouses running for state and federal office in the United States; and

Whereas, non-member physicians or physician spouses who are running for local, state, or federal office should also be encouraged to join the AMA, Alliance, and/or their state and specialty medical societies; and

Whereas, in this age of social media, it should be relatively easy to set up members-only websites with lists of appropriate physicians and physician spouses who are running for elected offices; and

Whereas, in the first version of this resolution submitted to the Missouri State Medical Association in 2024 two major concerns were raised: (1) potential legal implications, regarding coordination between state PACs, specialty society PACs and AMPAC, as well as (2) desire not to endorse physician candidates if they are not aligned with the policies of their state medical association and/or our AMA; and

Whereas, similar concerns were raised when a second version of this resolution was submitted to the Ohio State Medical Association (OSMA) in 2025, including:

- "An individual's campaign should do the work. Not every physician aligns with OSMA policy."
- "Promoting specific physician or spouses as candidates risk alienating OSMA members with differing political views."
- "It is more appropriate for OSMA to connect its members with opportunities to learn about candidacy";

and

Whereas, recent events in Minnesota highlight the courage of anyone running for (and/or holding) local or state elected office(s), as they and their families are constantly in the spotlight and potentially at risk; and

Whereas, given limited resources and bandwidth, it is likely that this proposal will need to be a collaborative effort between organized medicine and/or their respective political action committees; and

Whereas, it is unclear whether publicizing, supporting, and promoting such candidates should be a function of organized medicine (state and specialty societies and our AMA) versus their respective political action committees due to legal concerns, tax implications, etc.; and

Whereas, state and specialty societies or our AMA may also determine that certain physicians or physician spouses who are running for elected office may not merit recognition; and

Whereas, state and specialty societies or our AMA may also determine that certain words or actions of individuals running for elected office should merit removal from such lists; and

Whereas, there is already the National Council of State Legislatures and perhaps our AMA may wish to consider helping to organize a "National Convention of Physician and Physician Spouse State Legislators," perhaps in conjunction with the annual AMA State Advocacy Summit; therefore be it

RESOLVED, that our American Medical Association, to the extent permitted by applicable laws, collaborate with other interested organizations to facilitate opportunities for AMA physician-member and physician-spouse elected officials at the local and state levels to connect, exchange ideas, collaborate, and support each other to protect our patients and our practices, such as with a "National Meeting of Physician State Legislators" (Directive to Take Action); and be it further

RESOLVED, that our AMA study the:

1. Feasibility of collaborating with state medical societies and specialty societies to assess appropriate AMA physician members and physician spouses running for state and local offices and creating a “master list” to publicize, support, and promote those individuals, and
2. Opportunities to publicize this list widely to support appropriate physicians and physician spouses who are aligned with our priorities and encourage financial and social medial support of those candidates, with a report back at the 2027 Annual Meeting.

(Directive to Take Action).

Fiscal Note: Major - $252,348. Legal study, meeting planning and execution.

Received: 4/15/26

REFERENCES

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RELEVANT AMA POLICY

Encourage Physicians as Legislative Candidates G-640.025

1. Our American Medical Association will continue to identify, encourage, and support physicians to run as state and national legislative candidates.
2. Our AMA will not use AMA corporate treasury funds to engage in.

Citation: Res. 605, A-14; Consolidated with G-645.015: CCB/CLRDP Rep. 01, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-26)

Introduced by: LGBTQ+ Section

Subject: Increasing Expert Guidance in AMA Statements

Referred to: Reference Committee F

Whereas, on February 4, 2026, the American Medical Association publicized a statement regarding gender-affirming surgery for patients under 19, following the American Society of Plastic Surgeons' statement[1]; and

Whereas, LGBTQIA+ people have endured harm at the hands of the American healthcare system and organized medicine since medicine became formalized in this country[2-3]; and

Whereas, LGBTQIA+ people are currently experiencing political harm at an alarming level, with particular targets on the backs of transgender and gender diverse people as well as LGBTQIA+ minors[4-7]; and

Whereas, the AMA is the largest organized medical group of physicians and trainees in the country, and AMA's public statements as a result carry significant weight; and

Whereas, due largely to governmental overreach and political and financial pressures, with influence by public statements made by AMA and ASPS, preemptive compliance has further restricted care for not only adolescents, but adults, as made evident by many hospitals discriminatorily withdrawing gender-affirming surgical and/or medical care from transgender and gender diverse people, while still preserving gender-affirming care for cisgender people; and

Whereas, AMA policies H-185.927, H-160.991, and H-60.927 state our AMA's clear policy positions to protect access to gender-affirming care, to work with relevant partners and stakeholders to preserve the safety of LGBTQ+ physicians, patients, and those physicians that provide care to LGBTQ+ people, to lead in education of LGBTQ+ health, and to oppose criminalization, prohibition, or impositions upon gender-affirming care, including the care of minors; and

Whereas, though the statement itself does not explicitly counter policy, the phrasing used and the allowance of continued media manipulation without correction for weeks unintentionally serves to contradict the AMA's robust policies and contribute to disinformation and sensationalized narratives that seek to allow governmental restrictions in access to gender-affirming care for transgender people; and

Whereas, these restrictions harm not only transgender people, but cisgender people, as seen by physicians who provide many services beyond gender-affirming care avoiding working in states that restrict this care, as well as families of cisgender children fleeing their states to ensure access to medications that are being erroneously prohibited over the undue politicization of vulnerable minorities[8-11]; and

Whereas, reliance on experts in gender-affirming care provision, research, and advocacy could have shaped the nuances of the statement to support threading of the needle; and

Whereas, regardless of intention, the AMA has a responsibility to own and address the harmful effects it may cause as an institution; and

Whereas, our American Medical Association has a responsibility to advocate for the health, safety, and wellbeing of LGBTQ+ people and other vulnerable populations regardless of political climate, based in existing AMA policies; therefore be it

RESOLVED, that our American Medical Association consult with multidisciplinary AMA section-identified experts when crafting specialist care focused statements, especially statements predominantly discussing care for vulnerable populations, to reduce the risk of harm to said populations. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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11. HRC Foundation. Get the facts on gender-affirming care. Human Rights Campaign. Published March 22, 2023. https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care

RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;

   c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
   d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our American Medical Association will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(A-26)

Introduced by: LGBTQ+ Section

Subject: Preserving Institutional Equity and Inclusivity Efforts

Referred to: Reference Committee F

Whereas, health equity and inclusivity efforts are known to improve health outcomes, increase opportunities for minoritized populations, and enhance patient-physician relationships[1-5]; and

Whereas, AMA policies H-180.944, G-600.960, and D-295.963 clearly delineate the importance of equity and inclusivity work to benefit patients, trainees, and physicians, including that of the AMA itself; and

Whereas, AMA policy often directs the creation of resources to be made accessible to members and/or non-members; and

Whereas, equity and inclusivity work have been disappearing and reappearing altered from the AMA website, with hyperlinks that temporarily or permanently do not work without explanation of where this work has gone or for what purpose it has been modified, from documents and guidance on equity-focused language to EdHub resources on equity that were previously approved being suddenly considered out of line with EdHub materials to the rebranding and downsizing of the prior Center for Health Equity; and

Whereas, examples that have been either modified without explanation or removed temporarily or permanently as seen by faulty links, documented at the time of drafting this resolution, include the guide titled “Advancing Health Equity: A Guide to Language, Narrative, and Concepts”, the EdHub modules “Trauma-Informed Care for Trans and Gender Diverse Individuals” and the “Prioritizing Equity” video series items “Redistributive Justice", “Getting to Justice in Education”, “Moving Upstream”, “Political Determinants of Health”, with some being reinstated with modified titles and/or content[6-8]; and

Whereas, some AMA member contributors have been informed of changes, but it is variable based on topic, and this still neglects to address the loss of resources that members may rely on even if they who were not contributors to the work; and

Whereas, these changes are not in line with existing policy of the AMA and appear driven largely by shifting external priorities rather than true changes to the importance of equity and inclusivity in medicine, with variability in rationale being provided to contributors; therefore be it

RESOLVED, that our American Medical Association’s Board of Trustees ensure the restoration of resources that have been removed, with exceptions to archive rather than completely remove those resources that are out of date, being updated, or need to be removed for protection of parties involved in their creation (Directive to Take Action); and be it further

RESOLVED, that our AMA, when making changes to website resources, provide transparent communication and appropriate notice to all membership with forewarnings to members and staff involved in creation of those efforts that are being removed or altered or archived, even if

temporarily, and provide such communication retrospectively for those resources which have been modified already without AMA policy impetus to do so (Directive to Take Action); and be it further

RESOLVED, that our AMA only make changes up to and including removal to publicly available resources in line with policy changes. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our American Medical Association will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Continuing Equity Education G-600.960
Our American Medical Association will establish an Open Forum on Health Equity, to be held at least annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity.

Continued Support for Diversity in Medical Education D-295.963
Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
Our AMA will prioritize our organization's efforts to bolster diversity, equity, and inclusion across the medical education continuum.

Sunset Mechanism for AMA Policy G-600.110
Sunset policies will be retained in the AMA historical archives.

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted G-605.009
This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to health guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(A-26)

Introduced by: American Geriatrics Society

Subject: Inclusive Policy Language for Older Adults

Referred to: Reference Committee F

Whereas, the terms “seniors”, “elderly”, “aging dependents”, “old-old”, “young-old”, and similar “other-ing” terms stoke stereotypes of older adults; and

Whereas, during the AMA 2025 interim meeting there were resolutions that referenced older adults and used these terms; and

Whereas, the American Geriatrics Society and the AMA Manual of Style advise authors to avoid these “other-ing” terms because such terms connote discrimination and certain negative stereotypes that may undercut research-based recommendations for better serving us all as we age; and

Whereas, use of Inclusive Language in AMA Policy D-65.969 instructs the AMA to “ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments”; therefore be it

RESOLVED, that our American Medical Association will instruct all future policy language to use terms for those over the age of 65 to be “older persons”, “older people”, “older adults”, “older patients”, “older individuals”, “persons 65 years and older”, “the older population”, or preferred terminology from a specific group of older adults (e.g., Native American elders), in order to avoid a connotation of discrimination and negative stereotypes. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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2. American Medical Association (AMA) Manual of Style Committee. AMA Manual of Style: A Style Guide for Authors and Editors, 10th Ed. New York: Oxford University Press, 2007.
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RELEVANT AMA POLICY

Use of Inclusive Language in AMA Policy D-65.969
1. Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will amend existing policies to ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments.
2. Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will identify other types of outdated language in AMA policies and devise a timely mechanism for editorial

changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates.
Res. 007, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(A-26)

Introduced by: Resident and Fellow Section

Subject: Condemnation of Attacks on Healthcare Workers and Facilities in Gaza

Referred to: Reference Committee F

Whereas, the American Medical Association (AMA) has longstanding policies that oppose violence against healthcare workers, including:

- H-515.982 Violent Acts Against Physician, which condemns acts of violence against physicians and healthcare professionals;
- H-515.950 Protecting Physicians and Other Healthcare Workers in Society, which addresses harassment, intimidation, and threats against healthcare personnel;
- H-520.998 Medical Neutrality, which supports medical neutrality under the Geneva Conventions and advocating for the protection of healthcare workers and the sick and wounded in all countries;
- D-65.993 War Crimes as a Threat to Physicians' Humanitarian Responsibilities, which recognizes that war crimes, including the deliberate targeting of healthcare workers, threaten physicians' humanitarian responsibilities; and

Whereas, in 2023 the AMA Board of Trustees released a statement regarding the conflict in Israel and Gaza, stating that medical neutrality must be observed, physicians and healthcare personnel on the frontlines of crises worldwide must be able to provide medical care without fear of persecution, and reiterated the physicians' humanitarian responsibilities include sanctioning and condemning the military targeting of healthcare facilities and personnel[1]; and

Whereas, the Safeguarding Health in Conflict Coalition's 2024 report documented numerous attacks on healthcare personnel in Gaza, including "double tap" strikes whereby healthcare workers were killed during rescue efforts, and reported that health facilities were raided at least 28 times in 2024, each raid involving mass arrests of healthcare workers, damage to infrastructure, and destruction of medical equipment[2]; and

Whereas, Gaza's only medical school has been destroyed during the recent conflict[4]; and

Whereas, at least 40 medical students have been killed, 60 detained, and hundreds more displaced[5]; and

Whereas, the World Health Organization has documented 697 attacks on hospitals in Gaza since October 2023[8]; and

Whereas, the United Nations Human Rights Office reported that at least 1,581 healthcare workers have been killed in Gaza since October 7, 2023[6]; and

Whereas, Physicians for Human Rights–Israel reported deliberate bombing and forced evacuations of hospitals, rendering them non-functional and dismantling essential services such as trauma care, surgery, dialysis, and maternal health, and documented the killing and detention of over 1,800 healthcare workers, including the killings of department heads at Al-

Shifa Hospital in internal medicine, obstetrics-gynecology, emergency care, pathology, radiology, and orthopedics[7]; and

Whereas, B'Tselem, The Israeli Information Center for Human Rights in the Occupied Territories, reported that only 17 of Gaza's 36 hospitals were functioning, that 2.5% of medical personnel in Gaza had been killed, and that medical professionals had been arrested, abused, and killed while in detention[6]; and

Whereas, as of July 2025, Healthcare Workers Watch reported that over 400 Palestinian healthcare workers, including at least 28 doctors, had been detained by Israeli forces since October 2023, with many held for over 400 days without charge[9]; and

Whereas, the aforesaid principles of medical neutrality have been repeatedly violated in Gaza since the AMA Board of Trustees' 2023 statement, with healthcare workers targeted, detained, and killed, hospitals bombed, and medical services obstructed, in direct contravention of AMA policy[1]; therefore be it

RESOLVED, that our American Medical Association recognize the deliberate targeting of healthcare workers, medical students, and healthcare facilities in Gaza as a violation of medical neutrality and AMA policy (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to protect, release, and provide restitution to detained healthcare workers in Gaza. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

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RELEVANT AMA POLICY

Humanitarian and Medical Aid Support to Ukraine D-65.984
1. Our American Medical Association will advocate for continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US. 2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly. 3. Our AMA will advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22Modified: Speakers Rep. 02, I-24]

Violent Acts Against Physicians H-515.982
1. Our American Medical Association condemns acts of violence against physicians involved in the legal practice of medicine. 2. Our AMA will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity. 3. Our AMA will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers. 4. Our AMA will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise. [Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Reaffirmed: CSAPH Rep. 08, A-23]

Protecting Physicians and Other Healthcare Workers in Society H-515.950
1. Our American Medical Association acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers. 2. Our AMA will educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers including first responders, and public health officials, outside as well as within the workplace. 3. Our AMA will work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals. [Res. 413, I-20; Reaffirmed: CSAPH Rep. 7, I-23]

Medical Neutrality H-520.998
Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed in lieu of Res. 601, I-13; Reaffirmed: CEJA Rep. 05, A-23]

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993
1. Our American Medical Association will implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular. 2. Our AMA will support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs. 3. Our AMA will advocate for the protection of physicians’ rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19; Modified: Res. 002, I-22; Reaffirmed: Res. 603, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(A-26)

Introduced by: Resident and Fellow Section

Subject: Humanitarian and Medical Aid Support to Palestine

Referred to: Reference Committee F

Whereas, the Israel–Hamas conflict began on October 7, 2023, when Hamas-led militants launched a large-scale assault on southern Israel, resulting in the deaths of approximately 1,200 people and the abduction of around 251 hostages[1]; and

Whereas, since the conflict began, Gaza's Ministry of Health reports over 60,000 Palestinian deaths, mostly civilians, with independent estimates indicating the true toll may exceed 80,000 fatalities and an additional 160,660 are estimated to be wounded[2-4]; and

Whereas, data from an internal Israeli intelligence database suggests that at least 83% of Gazans killed were civilians, corroborating other reports that the dead are predominantly composed of civilians[5-8]; and

Whereas, the humanitarian crisis in Gaza includes widespread displacement, with nearly all of the 2.3 million residents internally displaced, alongside critical shortages in food, water, medicine, shelter, and the collapse of critical infrastructure, including medical facilities, educational institutions, and cultural centers[9-11]; and

Whereas, there are war-induced adversities affecting children that include but not limited to physical and/or mental health risks related to forced family separation, loss of access to school and healthcare, insecure access to food and shelter, and displacement from homes and Communities[12]; and

Whereas, war-related events cause significant mental health issues, particularly, depressive symptomatology among mothers further negatively affecting wellbeing of both mothers and their children[12]; and

Whereas, Gaza has the highest number of child amputees per capita anywhere in the world[13]; and

Whereas, the World Health Organization has documented hundreds of attacks on health care in Gaza since October 7, 2023, including strikes on hospitals, ambulances, and medical personnel, severely disrupting essential medical services[15]; and

Whereas, the UN Office of the High Commissioner for Human Rights has reported that at least 27 of Gaza's 38 hospitals have been struck, resulting in patient deaths, staff casualties, and the suspension of critical care[16]; and

Whereas, the International Committee of the Red Cross has condemned such strikes as unacceptable and detrimental to civilian care[20], while Physicians for Human Rights has recorded over 1,000 attacks on health workers, patients, ambulances, and infrastructure in the occupied

Palestinian territories since October 2023[21] and these sustained assaults have critically hampered the ability of physicians to practice medicine during wartime [22-23]; and

Whereas, our AMA has previously passed Humanitarian and Medical Aid Support to Ukraine D-65.984, a similar resolution to provide humanitarian and medical aid support to Ukraine[12]; therefore be it

RESOLVED, that our American Medical Association supports efforts to contribute funds to support the humanitarian crisis in Gaza (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for continuous support of organizations providing humanitarian missions and medical care to Palestinian refugees in Palestine, in nearby countries, and/or in the US (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an early implementation of mental health measures and address war-related trauma and post-traumatic stress disorder when dealing with Palestinian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

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RELEVANT AMA POLICY

Humanitarian and Medical Aid Support to Ukraine D-65.984
1. Our American Medical Association will advocate for continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US. 2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly. 3. Our AMA will advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22; Modified: Speakers Rep. 02, I-24]

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993
1. Our American Medical Association will implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular. 2. Our AMA will support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs. 3, Our AMA will advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19; Modified: Res. 002, I-22; Reaffirmed: Res. 603, A-24]

Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict H-520.985
1. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel. 2. Our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict. [Res. 603, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(A-26)

Introduced by: Resident and Fellow Section

Subject: Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association

Referred to: Reference Committee F

Whereas, in 2007, the AMA adopted policy D-250.990 which states “Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association”; and

Whereas, the AMA holds no such policy for any other member of the World Medical Association; and

Whereas, maintaining an unconditional stance on a country’s membership in the World Medical Association risks undermining the AMA’s credibility as an impartial global health leader, particularly when new evidence or circumstances may arise; and

Whereas, AMA should review and reevaluate policies related to international organizational memberships to ensure they reflect current facts, ethical standards, and the AMA’s commitment to human rights; therefore be it

RESOLVED, that our American Medical Association rescind AMA policy D-250.990 “Israeli Medical Association” which states “Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association” (Rescind HOD Policy); and be it further

RESOLVED, that our AMA's position on business in the World Medical Association (WMA) related to applications for constituent membership, or discipline or termination for current constituent members shall be based on the prevailing evidence at the time. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26/26

RELEVANT AMA POLICY

Israeli Medical Association D-250.990
Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association. [Res. 613, A-07; Reaffirmed: CEJA Rep. 04, A-17]

Medical Neutrality H-520.998
Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed in lieu of Res. 601, I-13; Reaffirmed: CEJA Rep. 05, A-23]

Human Rights and Health Professionals H-65.981
1. Our AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. 2. Our AMA reiterates its endorsement of the World Medical Association Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, which opposes participation by physicians in torture or other forms of cruel, inhuman or degrading procedures on detainees or prisoners. (https://World Medical Association Declaration of Tokyo) 3. Our AMA expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients. [Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15; Consolidated with H-65.991: CCB/CLRPD Rep. 01, A-25]

Medical Care in Countries in Turmoil H-65.994
1. Our American Medical Association supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster, military conflict or sanctions within their country through appropriate relief organizations. 2. Our AMA expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil. 3. Our AMA urges appropriate organizations to transmit these concerns to the affected country's government. 4. Our AMA asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems. [Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15; Modified: Res. 002, I-22]

Support of Human Rights and Freedom H-65.965
1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life, 2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age. 3. Our AMA opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. 4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. [CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22; Modified: Speaker Rep. 02, I-24]

Abuse of Medicine for Political Purposes H-65.993
The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur. [Res. 127, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmed: CEJA Rep. 5, A-15; Reaffirmed: CEJA Rep. 11, A-25]

Universal Access for Essential Public Health Services D-440.924
1. Our American Medical Association supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities. 2. Our AMA encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB). 3. Our AMA will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards. 4. Our AMA will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation’s public health system, including for rural jurisdictions. [Res. 419, A-19;

Modified: CSAPH Rep. 2, A-22]

Protecting Physicians and Other Healthcare Workers in Society H-515.950
1. Our American Medical Association acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers. 2. Our AMA will educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers including first responders, and public health officials, outside as well as within the workplace. 3. Our AMA will work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals. [Res. 413, I-20; Reaffirmed: CSAPH Rep. 7, I-23]

Health, In All Its Dimensions, Is a Basic Right H-65.960
1. Our American Medical Association acknowledges that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right. 2. Our AMA acknowledges that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. [Res. 021, A-19; Reaffirmed: Res. 234, A-22]

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. [Res. 001, A-18]

Nondiscrimination in Responding to Terrorism H-65.978
1. Our American Medical Association affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks. 2. Our AMA opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism. [Res. 1, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618
(A-26)

Introduced by: Resident and Fellow Section

Subject: Ending AMA Investment in Weapons Manufacturers

Referred to: Reference Committee F

Whereas, global military spending reached $2.7 trillion in 2024, and is estimated to reach $6.6 trillion by 2035[1,2]; and

Whereas, more than half of the US military budget is spent on military contractors including weapons manufacturers, at a time when investments in health care, education, and research are declining[3]; and

Whereas, from 2020 to 2024, $771 billion in US military spending went to just five publicly-traded weapons manufacturers[3,4]; and

Whereas, attacks on health care facilities and personnel are rising to unprecedented levels, with over 2,500 incidents in 2023 and over 3,600 incidents in 2024[5]; and

Whereas, the arms industry has been labeled as a “commercial determinant of health”, with calls for divestment from the arms industry for health[6,7]; and

Whereas, financial ties to weapons manufacturers are fundamentally incompatible with the mission of physicians as healers who do no harm, and of the AMA’s mission to promote the betterment of public health; and

Whereas, the World Medical Association “believes that the development, manufacture and sale of weapons for use against human beings are abhorrent”[8]; and

Whereas, our AMA has previously labeled gun violence as a public health crisis (D-145.995); and

Whereas, our AMA has previously divested from tobacco manufacturers and the fossil fuel industry (H-135.921; H-500.975); therefore be it

RESOLVED, that our American Medical Association divest from all companies that derive a majority of their revenue from the manufacturing of weapons, cluster munitions, chemical, biological, or nuclear weapons, or key component of these weapons (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates at A-27 on what progress has been made towards divestment. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/21/266

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RELEVANT AMA POLICY

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our American Medical Association will:
    a. choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
    b. support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA:
    a. declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe.
    b. urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
    c. will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest. [BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22]

AMA Corporate Policies on Tobacco H-500.975

1. Our American Medical Association:
    a. continues to urge the federal government to reduce and control the use of tobacco and tobacco products;
    b. supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and
    c. will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications.
2. Our AMA will continue to use appropriate lobbying resources to support programs of anti-tobacco health promotion and advertising.
3. Our AMA's House of Delegates endorses the April 24, 1996, statement by the AMA Secretary-Treasurer that all physicians, health professionals, medical schools, hospitals, public health advocates, and citizens interested in the health and welfare of our children should review their personal and institutional investments and divest of any tobacco holdings (including mutual funds that include tobacco holdings); and specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings.

4. Our AMA defines the Tobacco Industry as companies or corporate divisions that directly produce or purchase tobacco for production or market tobacco products, along with their research and lobbying groups, including the Council for Tobacco Research and the Smokeless Tobacco Research Council. A company or corporate division that does not produce or market tobacco products but that has a tobacco producing company as or among its owners will not be considered a prohibited part of the tobacco industry as long as it does not promote or contribute to the promotion, sale and/or use of tobacco products. If such promotional practices begin, the company will be placed on an "unacceptable for support" list.
5. Accordingly, it is the policy of our AMA:
    a. not to invest in tobacco stocks or accept financial support from the tobacco industry;
    b. to urge medical schools and their parent universities to eliminate their investments in corporations that produce or promote the use of tobacco and discourage them from accepting research funding from the tobacco industry;
    c. to likewise urge all scientific publications to decline such funded research for publication; and
    d. to encourage state and county medical societies and members to divest of any and all tobacco stocks.
6. Our AMA:
    a. encourages state and local medical societies to determine whether candidates for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public; and
    b. urges state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, given recent allegations about tobacco industry strategies.

[CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Further Action to Respond to the Gun Violence Public D-145.992

1. Our American Medical Association will make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence.
2. Our AMA will establish a task force to focus on gun violence prevention including gun-involved suicide.
3. Our AMA will support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics.
4. Our AMA will collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety.
5. Our AMA will report annually to the House of Delegates on our AMA’s efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

[BOT Rep. 2, I-22 Reaffirmation: Res. 431, A-24]

Gun Violence as a Public Health Crisis D-145.995

1. Our American Medical Association will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution.
2. Our AMA will actively lobby Congress to lift the gun violence research ban.

[Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22; Reaffirmed: CSAPH Rep. 11, A-24; Reaffirmation: Res. 431, A-24]

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our American Medical Association recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore our AMA:
    a. encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
    b. urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
    c. urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

   d. urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
   e. encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
   f. urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
   g. strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

[CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22; Reaffirmation: A-23; Reaffirmed: CSAPH Rep. 11, A-24; Reaffirmation: Res. 431, A-24]

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of our American Medical Association to:

1. Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
   a. Mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers.
   b. Bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21.
   c. Bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel).
   d. The imposition of significant licensing fees for firearms dealers.
   e. The imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society.
   f. Mandatory destruction of any weapons obtained in local buy-back programs.
2. Support legislation outlawing the Black Talon and other similarly constructed bullets.
3. Our AMA support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
4. Our AMA opposes “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with

concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

5. Our AMA supports the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

[BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18; Reaffirmation: I-22]

Reference Committee G

Report(s) of the Board of Trustees

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22 Comprehensive AMA Policy Publication Regarding Employed Physicians

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Resolutions

701 The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
702 Physicians Who Do Not Practice in Hospital Setting
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704 Advocating Against Automatic Refill Requests
705 Recognizing Physicians as Sexual Assault Forensic Examiners
706 Discharge Summaries from Skilled Nursing Facilities
707 Malpractice Insurance for Employed Physicians
708 Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
709 Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
710 Parity in Access to Evidence-Based Obesity Treatment
711 Oppose Denials Based on Origin of Referral
712 Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
713 Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
714 Physician Case Log Portability
715 Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA
716 Equal Opportunity for Payment for “On Call” Duty
717 Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

REPORT OF THE BOARD OF TRUSTEES

BOT Report 20-A-26

Subject:	Mitigating the Impact of Excessive Prior Authorization Processes; (Resolution 704-A-25, Resolve 2)
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee G

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

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

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

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

BACKGROUND

Prior authorization is a process used by health insurers requiring physicians to receive approval from plans before certain prescribed medications, procedures, or treatments can be provided to patients. While intended to control costs and ensure medical necessity, prior authorization has become a significant administrative burden for physicians. Per the American Medical Association ("AMA") Prior Authorization Survey conducted in 2024[i], ninety-three percent of physicians report that prior authorization leads to delays in patient care, and eighty-two percent say it results in patients abandoning treatment due to these barriers.[ii] Most alarmingly, more than one-quarter of physicians report that such delays have resulted in serious adverse events for

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patients—including hospitalization or death.[iii] In addition, the average weekly prior authorization workload for a single physician consumes 13 hours of physician and staff time, with 89 percent of physicians saying that prior authorization increases burnout. These findings underscore the urgent need for reform to reduce administrative friction and protect patient access to timely care.

Relevant Current AMA Policy

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

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

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

DISCUSSION

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

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

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Class Actions are Difficult to Bring

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

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

Restrictions on Prior Authorization are Intended to Protect Patients

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

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

Other Considerations

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

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Further, physician network contracts almost always include provisions that (a) require pre-dispute arbitrations and (b) prohibit consolidation of claims, of which a class action would be an extreme example. Courts have routinely upheld network contract arbitration clauses in disputes between healthcare providers and payors.[xv]

CONCLUSION

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

RECOMMENDATIONS

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

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

Fiscal Note: No Significant Fiscal Impact

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[i] 2024 AMA Prior Authorization Physician Survey *located at:*https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[ii] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[iii] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[iv] Wal-Mart Stores, Inc. v. Dukes, 564 U.S. 147, 161 (2011) (holding that Rule 23(a)'s requirements "are not mere pleading standards" and must be proven with evidentiary support at certification).
[v] Fed R. Civ. P. 23(a)(1).
[vi] Fed R. Civ. P. 23(a)(2).
[vii] Fed R. Civ. P. 23(a)(3)
[viii] Fed R. Civ. P. 23(a)(4)
[ix] "Doctors Target Insurers' Prior Authorization Policies in Legislative Push," MedPage Today, March 2023 *located at*: https://www.medpagetoday.com/special-reports/features/98337.
[x] https://medcitynews.com/2025/04/gold-carding-prior-authorization/
[xi] National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025 *located at*: https://content.naic.org/sites/default/files/national_meeting/PA%20white%20paper%2012.4.2025%20final.pdf
[xii] 89 Fed. Reg. 8,759-60 (Feb. 08, 2024).
[xiii] National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025 *located at*: https://content.naic.org/sites/default/files/national_meeting/PA%20white%20paper%2012.4.2025%20final.pdf
[xiv] https://www.ncsl.org/health/health-insurance-how-states-are-reforming-the-prior-authorization-process

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

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 22-A-26

Subject: Comprehensive AMA Policy Publication Regarding Employed Physicians

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee TBD

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

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

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

BACKGROUND

Practice model options

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

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

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

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

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

Trends in practice ownership and physician employment

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

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

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

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

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

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

Trends in physician unionization

While the number of physicians who are members of unions is small compared to the size of the profession, that share is growing. The AMA has estimated that between 2014 and 2019 the share of physicians who were union members increased from 5.7 percent to 7.2 percent.[3] This trend appears to be accelerating, as highlighted by a *JAMA* study analyzing trends in the number of petitions filed with the National Labor Relations Board to form unions with physician members; there were 44 such petitions filed between 2000 and 2022 – and an additional 33 filed in 2023-2024 alone.[4] The same study found that physicians are motivated to organize unions primarily due to "concerns about working conditions, physicians' autonomy, and voice in management, and the quality of patient care."[5]

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

DISCUSSION

Challenges of physician employment

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

- Decreased clinical autonomy: Physicians may have less control over clinical decisions and daily operations due to complex leadership structures in larger organizations.

- Reduced influence in decision-making: Employment in larger organizations can limit opportunities for physicians to participate in high-level decisions affecting clinical practice or workplace operations.

- Alignment with organizational goals: Physicians must adapt to employer-set policies and values, which may differ from their own practice philosophies.

- Performance metrics and targets: Physicians may feel pressured to meet benchmarks set by employers, which can at times be perceived as emphasizing productivity or administrative tasks over individualized patient care.

- New administrative demands: Employment structures may simply replace the administrative demands of independent practice with a new set of administrative demands, adding to workload and impacting job satisfaction.

- Potential for burnout: These challenges can affect physician professional satisfaction and lead to burnout.[6]

Addressing the challenges of physician employment

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

- Has the organization conducted an AMA Organizational Biopsy®, or other biopsy assessment, to measure and take action to improve the health of the organization in areas

critical to physician well-being, such as organizational culture, practice efficiency, self-care, and retention?

- Has the organization applied for or received recognition through the AMA Joy in Medicine™ Health System Recognition Program for its efforts to combat burnout and promote a culture of wellness at the organizational level?

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

Other AMA resources for employed physicians

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

- The AMA Annotated Model Physician-Group Practice Employment Agreement and the AMA Physicians' Guide to Hospital Employment Contracts provide comprehensive guidance for understanding, evaluating, and negotiating key terms and implications of physician employment contracts. Additionally, the AMA has published a six-part podcast series exploring contract negotiation.

- As a benefit of membership, AMA members receive a 20 percent discount on contract review packages and salary data from Resolve, an industry leader in physician employment contract review.

- The AMA Principles for Physician Employment, codified as AMA policy H-225.950, provide guidance to help physicians and their employers navigate unique challenges to professionalism and patient care arising from employment relationships, addressing issues such as conflicts of interest, advocacy for patients and the profession, contracting, medical staff relations, peer review, and payment agreements.

- The AMA Physician's Guide to Medical Staff Organization Bylaws is designed to assist medical staffs with drafting or amending medical staff bylaws and understanding how emerging issues in health care impact medical staff. Notably, the Guide addresses issues specific to employed physicians within the context of the medical staff, such as hearing rights for employed physicians.

- AMA STEPS Forward® is a collection of resources covering everything from time-saving strategies and preventing physician burnout to improving practice workflows, building a supportive organizational culture, and implementing digital health solutions that reduce technology-associated administrative burdens.

- The AMA Joy in Medicine® Health System Recognition Program is a prestigious AMA-granted distinction in recognition of an organization's demonstrated efforts to enhance physician well-being by resolving the root causes of work-related burnout.

- The AMA Organizational Biopsy® is an assessment tool and set of services developed by the AMA to assesses burnout levels within health care organizations to provide metrics that

can guide solutions and interventions that mitigate system-level burnout rates and improve physician well-being.

- The AMA issue brief, Collective bargaining for physicians and physicians-in-training, provides an overview of trends in physician unionization, examines the factors driving physicians to join unions, and discusses the implications of union membership for physicians and the broader healthcare system.

- The AMA Organized Medical Staff Section (OMSS) has convened an employed physician caucus to amplify the voice and issues of employed physicians in AMA policy development. Members may contact the OMSS (omss@ama-assn.org) to learn more.

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

CONCLUSION

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

RECOMMENDATION

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

REFERENCES

1. American Medical Association. Policy Research Perspectives – Physician Practice Characteristics in 2024: Private Practices Account for Less than Half of Physicians in Most Specialties. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf. Accessed March 5, 2026.
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RELEVANT AMA POLICY

D-225.971 Comprehensive AMA Policy Publication Regarding Employed Physicians

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

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-26

Subject: Council on Medical Service Sunset Review of 2016 House Policies

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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.

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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

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 physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.	Retain. Policy is relevant.
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;	Sunset. Directive was accomplished.

POLICY #	Title	Text	Recommendation
		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.	
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 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.	Retain. Policy is relevant.
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 tran smission 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.

POLICY #	Title	Text	Recommendation
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 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.	Retain. Policy is relevant.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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 evidence-based evaluation to justify the expenditures for the recommendations it makes.	Retain. Policy is relevant.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		physicians about the impact of proposed changes to Medicaid via SPAs.	
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.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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."	
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.
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 provid e our members with the tools and information necessary to analyze the impact on their patients, their practice	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		, and 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.	
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 ((EMSC)); (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.

POLICY #	Title	Text	Recommendation
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 ser vices 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 Restricted Distribution Systems by Pharmaceutical Manufacturers	1. Our AMA will advocate with interested parties for legislative or regulatory measures that require 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.	Retain. Policy is relevant.
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-	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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 Team-Based Health Care	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 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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. 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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 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.	Retain. Policy is relevant.
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.

POLICY #	Title	Text	Recommendation
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 se lection 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 treatments; and (2) local and state efforts to promote reproductive health insurance coverage r egardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.	Retain. Policy is relevant.
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 establishe d in disadvantaged communities and in areas of critical physician need.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
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 Commissi on (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.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		impending changes in 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.

POLICY #	Title	Text	Recommendation
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 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.	Retain. Policy is relevant.
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.

POLICY #	Title	Text	Recommendation
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.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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 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.	Retain. Policy is relevant.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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 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.	Retain. Policy is relevant.
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.

POLICY #	Title	Text	Recommendation
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.
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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		"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. 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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.
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.

POLICY #	Title	Text	Recommendation
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 a nd substance 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 facilitie s 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 of method of payment, where permissible by law or contractual agreement.	Retain. Policy is relevant.
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.

POLICY #	Title	Text	Recommendation
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 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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**~~**e**mergency ~~**D**~~**d**epartment ~~**P**~~**p**atient ~~**E**~~**e**xperience of ~~**C**~~**c**are ~~**(EDPEC)**~~ ~~**S**~~**s**urvey**s** 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:	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		A. Medical care outside of the US must be voluntary. 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.	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.

POLICY #	Title	Text	Recommendation
		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 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		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.	
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 further research on stem cell tourism, and (c) urges physicians to educate themselves on these issues.	Retain. Policy is relevant.
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 could 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	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.	
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 standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.	Retain. Policy is relevant.
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.

POLICY #	Title	Text	Recommendation
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. 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.	Retain. Policy is relevant.
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.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-26

Subject: Expanding Medicare Coverage of Medical Nutrition Therapy

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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 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

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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.

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).

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. (New HOD Policy)
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). (New HOD Policy)
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. (Reaffirm HOD Policy).
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. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform. (Reaffirm HOD Policy)

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.

(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)

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.
    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)

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.
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)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-26

Subject:	Study of Practice Models for Physicians Performing Procedures Across State Lines
Presented by:	Betty Chu, MD, MBA, Chair
Referred to:	Reference Committee G

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

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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]

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 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.

    (New HOD Policy)

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. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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[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.

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 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
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(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;

(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)

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Private Insurance Coverage of Anti-Obesity Medications

EXECUTIVE SUMMARY

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 marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations. Obesity is a chronic, progressive disease and a global public health challenge. While seven medications are currently approved for weight loss, the next generation of AOMs will enter the market within the next few years and are considered more effective with fewer side effects. Despite an increasing body of evidence to suggest that AOMs are effective treatments, coverage for obesity remains limited. The World Health Organization and Institute for Clinical and Economic Review recently released reports providing guidance on the use of glucagon-like peptide-1 (GLP-1) medications, strategies to guide market action, policy solutions, and federal policy interventions to improve access. Furthermore, the regulatory environment has been dynamic, with GLP-1s included in the Trump Administration's priority to lower prescription drug prices.

The Council on Medical Service recommends new policy supporting potential innovative payment arrangements and pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management. The Council also recommends 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. Furthermore, the Council recommends equitable access to comprehensive disease management, health promotion, and prevention interventions targeting the general population and those who are at elevated risk for obesity. Additionally, the Council recommends reaffirming Policy H-110.997 and Policy H-110.959 to emphasize the AMA's support for affordable access to prescription drugs. The Council also recommends reaffirming Policy H-110.987 to highlight the AMA's support to ensure that drug prices are affordable to patients and Policy D-330.954 and Policy D-110.987 to underscore the AMA's support and recognition for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS and efforts to increase pharmacy benefit manager transparency and regulation. Lastly, the Council recommends reaffirming Policy H-150.953 to highlight the AMA's recognition of obesity as a complex health disorder.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-26

Subject: Private Insurance Coverage of Anti-Obesity Medications

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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:

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>
> 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 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

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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.

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]

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 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.

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 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.

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.

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. (New HOD Policy)

2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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**.** (Reaffirm HOD Policy)

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	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:	2023

Weekly subcutaneous injection		• 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.	

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.
   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;
    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).
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)

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)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-26

Subject: Nonprofit Status

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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.

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- 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 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.

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.

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" 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. (Modify Current HOD Policy)

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.
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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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-26)

Introduced by: Private Practice Physicians Section

Subject: The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models

Referred to: Reference Committee G

Whereas, the COVID-19 pandemic revealed the strength of U.S. physicians' professionalism and intrinsic motivation as physicians (and other healthcare professionals) learned rapidly and did what needed to be done—no performance measures or financial incentives from value-based programs (VBPs) were required to prompt their efforts; and

Whereas, VBP models risk undermining these strengths and our greatest resource for improving care[1]; and

Whereas, VBP model metric reporting and demoralizing score boosting tasks coupled with the burden of an average of 7.3 hours in electronic health records per eight hours of scheduled patients have led to a "burnout" epidemic among primary care clinicians[2, 3, 4]; and

Whereas, the work of VBP programs was acknowledged by the Centers for Medicare & Medicaid Services as they relieved physicians of reporting requirements "so the healthcare delivery system can direct its time and resources toward caring for patients"[5]; and

Whereas, in 2024, compliance costs of the Merit-Based Incentive Payment System resulted in penalties for 32 percent of small practices and 46 percent of solo practitioners[6]; and

Whereas, free medical education appears ineffective at encouraging students to pursue primary care as evidenced by 2024 data showing U.S. medical school graduates filled only 35 percent of categorical internal medicine residency positions and non-U.S. citizen international graduates filled 30 percent[7]; and

Whereas, worrisomely, a 2023 Elsevier survey revealed that over half of U.S. medical students envisioned their education as a stepping stone to careers outside direct patient care[8]; and

Whereas, the Pay Primary Care Providers Act, currently before the 119th Congress, seeks to increase primary care physician reimbursement in hopes of bolstering primary care but also seeks to move more physicians and patients into VBP arrangements (capitation); and

Whereas, these measures are not expected to save money and doubling down on VBP models will exacerbate the exodus of physicians from primary care fields[9,10]; and

Whereas, it is evident that relying on physician resilience, dedication, adjustments to VBP programs, streamlining reporting requirements (Data-Driven Performance System proposed by the AMA), team-based care, efforts to increase the number of students pursuing primary care, optimizing technology, forthcoming advances promised by artificial intelligence, and even

increasing compensation for primary care physicians are insufficient to address the crisis in the availability of primary care physicians; and

Whereas, ignoring this crisis will, ultimately, relegate our patients to a lower standard of care, as numerous county and state health commissioners support independent practice by physician assistants and nurse practitioners to alleviate the shortage of primary care physicians; and

Whereas, the consensus opinion is that the vast majority of VBP models have failed to reduce healthcare expenditures or improve the quality of life meaningfully with considerable evidence that they have resulted in the opposite—increasing costs and declining quality of care[11,12,13,14]; and

Whereas, small independent practices (ten or fewer physicians) have 33 percent fewer preventable hospital admissions and lower per-beneficiary spending than larger practices, thus removing obstacles to their survival is an efficient way to lower costs and improve the quality of care[15,16,17]; therefore be it

RESOLVED, that our American Medical Association will advocate for the immediate discontinuation of required participation in value-based programs (VBP) arrangements for practices with ten or fewer physicians, regardless of practice revenue. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received:

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RELEVANT AMA POLICY

Value-Based Insurance Design H-185.939

Our American Medical Association supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).

Citation: CMS Rep. 2, A-13; Reaffirmed in lieu of: Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-18; Reaffirmed; CMS Rep. 06, A-19; Reaffirmed: BOT Rep. 14, A-23.

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors

that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.
Citation: Res. 247, A-18; Reaffirmed: BOT Rep. 13, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-26)

Introduced by: Pennsylvania

Subject: Physicians Who Do Not Practice in Hospital Setting

Referred to: Reference Committee G

Whereas, in order to address payment issues associated with unfair insurance panels, our AMA created policy D-230.981 which states:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.; and

Whereas, in response to this AMA policy some insurance payers in Pennsylvania adopted insurance requirements of some other states, to require that their network physicians have hospital privileges; and

Whereas, this imposes an unreasonable burden on physicians who do not work in hospital settings; and

Whereas, when a hospital ceases operations, a physician credentialled only at that hospital may lose their network status jeopardizing access to care for their patients; therefore be it

RESOLVED, that our American Medical Association amend D-230-981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. <u>Our AMA advocate that hospital privileges not be a requirement for insurance network participation.</u>

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/26

RELEVANT AMA POLICY

D-230.981 Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.

Res. 238, I-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-26)

Introduced by: Obesity Medicine Association

Subject: Parity in Pricing for Anti-Obesity Medications

Referred to: Reference Committee G

Whereas, our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention; and

Whereas, our AMA has elevated obesity to be one of its public health priorities, advocating for the creation of a multidisciplinary federal task force to better recognize and treat obesity as a chronic disease; and

Whereas, existing AMA policy (H-150.953) urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs; and

Whereas, in spite of this policy, the majority of private insurers do not cover anti-obesity medication treatments, and patients are accessing these treatments purchasing directly from pharmaceutical manufacturers; and

Whereas, AMA policy (H-440.801) explicitly supports allowing a patient's established physician to prescribe anti-obesity medication and have it covered by insurance, without requiring that patients receive the prescription only from contracted disease management companies; and

Whereas, pharmaceutical manufacturers have recently agreed to sell GLP-1 anti-obesity medications to telehealth companies at a reduced cost; and

Whereas, these discounted pricing structures threaten established doctor-patient relationships by inappropriately incentivizing patients to abandon their regular physicians to pursue care with telehealth companies solely to access lower medication prices; and

Whereas, obesity medicine practices are increasingly being driven out of business due to patient diversion to closed networks by insurers, as well as patients seeking coverage through med spas or by filling out online forms; and

Whereas, this diversion contradicts current AMA policy, which explicitly advocates for allowing a patient's established physician to prescribe anti-obesity medication and have it covered by insurance, without the requirement that patients must receive their prescription only from contracted disease management companies; and

Whereas, offering preferential pricing for customers of online sales models further degrades the ability of patients to receive continuous, comprehensive obesity care from their primary care or established obesity medicine physician; therefore be it

RESOLVED, that our American Medical Association actively oppose preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/13/26

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RELEVANT AMA POLICY

Advocacy Against Obesity-Related Bias by Insurance Providers (H-440.801):
This policy supports allowing a patient's established physician to prescribe anti-obesity medications and have them covered by insurance, without requiring that patients receive the prescription exclusively from contracted disease management companies. (Res. 224, A-23; Appended: Res. 230, A-25)

Obesity as a Major Public Health Problem (H-150.953):
This policy urges all payers to ensure coverage parity for the evidence-based treatment of obesity, which includes 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)

Recognition of Obesity as a Disease (H-440.842):
This policy formally establishes that the AMA recognizes obesity as a disease state with multiple pathophysiological aspects that require a range of interventions to advance treatment and prevention. (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)

Recognizing and Taking Action in Response to the Obesity Crisis (D-440.980):
This directive elevates obesity to one of the AMA's primary public health priorities and advocates for a multidisciplinary federal task force to better recognize and treat obesity as a chronic disease. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified - BOT Action in response to referred for decision: Res. 403, A-21; Appended: Res. 427, A-25)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-26)

Introduced by: Mississippi

Subject: Advocating Against Automatic Refill Requests

Referred to: Reference Committee G

Whereas, multiple studies show the tremendous financial and human resource burden imposed upon physician practices by health insurance companies; and

Whereas, while filling medications is foundational to Prescription Drug Adherence (PDA), it does not guarantee that a patient will take the medication as prescribed; and

Whereas, patients must have regular visits with physicians (as well as laboratory studies) in order to safely continue medication orders; and

Whereas, non-patient-initiated refill requests are burdensome to the physician and often unnecessary; and

Whereas, non-patient-initiated refill requests could cause physicians to errantly approve a medication without an appropriate history, exam, and pertinent laboratory studies; therefore be it

RESOLVED, that our American Medical Association communicate effectively with large pharmacy chains and conglomerates for the purpose of explaining the unnecessary administrative burden of automatic, non-patient-initiated refill requests and petitioning them to require all medication refill requests use a patient directed “opt-in” approach (Directive to Take Action); and be it further

RESOLVED, that our AMA petition the Centers for Medicare and Medicaid Services to restrict participating pharmacies from sending medication refill requests to physicians unless the patient “opts-in” to using the refill request. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/13/26

RELEVANT AMA POLICY

D-120.984 Streamlining the Process for Prescription Refills
Our American Medical Association will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. [Sub Res. 522, A-03 Reaffirmed: BOT Rep. 8, A-11 Reaffirmed: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-26)

Introduced by: American Academy of Family Physicians

Subject: Recognizing Physicians as Sexual Assault Forensic Examiners

Referred to: Reference Committee G

Whereas, there is a national shortage in Sexual Assault Forensic Examiners, resulting in delays in care for sexual assault survivors[1]; and

Whereas, rural areas and tribal communities have the largest gap in sexual assault examiner coverage[2,3]; and

Whereas, he standard of care as listed in the Department of Justice's "A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents" Third Edition (2024) states: "Clinicians, in the context of the medical forensic examination, may be registered nurses, advanced practice nurses, physician assistants or physicians, depending on factors such as local protocols, support for specialized clinical programs, and available education."[4]; and

Whereas, the American College of Emergency Physicians' 2022 Model of the Clinical Practice of Emergency Medicine includes "Sexual assault examination" within the section Procedures And Skills Integral To The Practice Of Emergency Medicine[5]; and

Whereas, physicians, including family medicine physicians, emergency medicine physicians, and pediatricians are part of the workforce that comprises Sexual Assault Medical Forensic Examiners; therefore be it

RESOLVED, that our American Medical Association Policy H-80.999 "Sexual Assault Survivors" be amended from "Our AMA will advocate for increased patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations." to "Our AMA will advocate for increased patient access to Sexual Assault Forensic Examiners in the emergency department for medical forensic examinations," (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA Policy H-80.999 be amended from "Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers." to "Our AMA supports the implementation of a national database of Sexual Assault Medical Forensic Examiners." (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

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4. A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents Third Edition U.S. Department of Justice Office on Violence Against Women, September 2024, https://www.justice.gov/ovw/media/1367191/dl?inline
5. Beeson MS, Bhat R, Broder JS, et al. The 2022 Model of the Clinical Practice of Emergency Medicine. J Emerg Med. 2023;64(6):659-695. doi:10.1016/j.jemermed.2023.02.016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-26)

Introduced by: New York

Subject: Discharge Summaries from Skilled Nursing Facilities

Referred to: Reference Committee G

Whereas, when patients transition between different settings, i.e. community to hospital, hospital to skilled nursing facility (SNF), and SNF to community, the quality of care and patient safety can be compromised due to high rates of medication errors, incomplete/inaccurate information transfer, and lack of follow-up care (1,2,3,4,5,6), and

Whereas, published recommendations for optimization of transitions of care including a 2016 best practice consensus from SGIM-AMDA-AGS (7) includes a recommendation that SNFs transmit a formal discharge summary to the patient's outpatient PCP within 72 hours of patient discharge from SNF; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) has issued a policy regulation (8) in 2017 requiring SNFs to create a discharge summary that includes but is not limited to a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, medications/ Medication Reconciliation and pertinent lab, radiology, and consultation results, to improve follow-up care; therefore be it

RESOLVED, that our American Medical Association educate their members as to Centers for Medicare and Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-26)

Introduced by: New York

Subject: Malpractice Insurance for Employed Physicians

Referred to: Reference Committee G

Whereas, an increasing percentage of physicians are employed by a variety of corporate structures; and

Whereas, employers often select “claims-made” malpractice insurance policies to reduce expenses; and

Whereas, the gold standard for malpractice coverage is an “occurrence” policy, which provide coverage for any incident that occurs during the policy period, regardless of when the claim is filed; and

Whereas, a claims-made policy requires the purchase of a costly “tail” policy after leaving employment to maintain coverage for prior acts, and the cost of this tail coverage may be prohibitive; therefore be it

RESOLVED, that our American Medical Association support a requirement for employers to purchase only occurrence malpractice insurance policies for their employed physicians, fellows and residents. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-26)

Introduced by: New York

Subject: Oppose Imposition of Fees on Physicians for Electronic Payment Transfers

Referred to: Reference Committee G

Whereas, AMA Advocacy has on multiple occasions asked for halfway measures, and instead of asking to ban VCC (virtual credit cards) on ERA transactions, it has asked for "further study at an NCVHS meeting"; and

Whereas, AMA advocacy, well aware that CMS "Guidance" does not carry the weight of law as has been pointed out to it on numerous occasions at the AMA PPPS meeting and AMA meetings, has asked CMS recently for more of the same, well aware that another Guidance will provide zero benefit to physicians; and

Whereas, "Guidance" issued by federal agencies does not carry the weight of law and is "non-enforceable, which is well-known to any attorney vaguely familiar with the Administrative Law (and it states so on the bottom of every Guidance issued by CMS), however despite that being pointed out the AMA Advocacy, the AMA persists in asking CMS to do what is illegal: enforce a non-enforceable "Guidance" in June 10, 2025 letter to CMS, instead of asking CMS for what is really needed, a legally sound regulation issued in an APA (Administrative procedure act compliant manner with 60 day notice and comment period; and

Whereas, AMA Advocacy adopted the talking points of Visa, MasterCard, Zelis, and UHC that "virtual credit cards" are legal, whereas there is no legal basis for such assertion, as they have never been adopted or proposed to be adopted under an APA-compliant process; therefore be it

RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rules compliant with the Administrative Procedure Act with a notice and comment period preventing the use of virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/14/26

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2. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfh.zip/2025-7-10-Letter-to-Kennedy-re-HHS-RFI-on-Deregulation-v3.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-26)

Introduced by: New York

Subject: Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine

Referred to: Reference Committee G

Whereas, health plans require preauthorization for certain tests, procedures, consultations, treatments, and medications, and such determinations may affect patient diagnosis, treatment, and outcomes; and

Whereas, physicians requesting preauthorization are required to identify themselves to insurance utilization review entities, including providing their National Provider Identifier (NPI); and

Whereas, under the Health Insurance Portability and Accountability Act (HIPAA), physicians must verify the identity and authority of individuals requesting access to a patient's protected health information when those individuals are not already known to them; and

Whereas, utilization review and peer-to-peer review processes may involve physicians making determinations that directly affect patient care, yet in some instances such reviewers do not disclose their identity to the requesting physician; therefore be it

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Privacy Act (HIPAA), and allow for accountability should the decision be called into question (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in New York State and therefore, accountable to New York State authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association amend their Policy H-285-939, subsection (2) to amended to read as follows:

That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services <u>including prior authorizations</u>.

(2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.
(Modify Current HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-26)

Introduced by: American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Obesity Medical Association, American Academy of Sleep Medicine, American Association of Clinical Endocrinology, Medical Student Section

Subject: Parity in Access to Evidence-Based Obesity Treatment

Referred to: Reference Committee G

Whereas, the American Medical Association recognized obesity as a disease state with multiple pathophysiological aspects in 2013 (H-440.842) and elevated obesity as a top-tier public health priority in 2025 (D-440.980); and

Whereas, the prevalence of obesity among adults in the United States has risen from 30.5% in 1999–2000[1] to 41.9% in 2017–2020[2], and current estimates exceed 42%, with severe obesity (BMI ≥40) affecting approximately 9.7% of the adult population[3]; and

Whereas, the prevalence of obesity among children and adolescents in the United States is approximately 19.7%[4], having tripled since 1980, and affected youth face increased lifetime risk of type 2 diabetes, cardiovascular disease, and psychosocial harm, yet pediatric obesity treatment faces many of the same coverage barriers as adult treatment; and

Whereas, obesity is a root cause of more than 200 comorbid conditions[5] including type 2 diabetes, cardiovascular disease, certain cancers, obstructive sleep apnea, and nonalcoholic fatty liver disease, and is estimated to contribute to approximately 300,000 excess and premature deaths annually in the United States[6]; and

Whereas, the annual economic cost of obesity in the United States is estimated to exceed $260 billion in direct medical costs and lost productivity[7], representing a significant burden on the healthcare system, employers, and patients; and

Whereas, despite the AMA's recognition of obesity as a chronic disease more than a decade ago, a systematic and pervasive failure of payers to provide equitable coverage for evidence-based obesity treatments persists[8], creating a treatment access crisis unlike that faced by patients with any other AMA-recognized chronic disease; and

Whereas, Medicare Part D has historically excluded coverage of anti-obesity medications under Section 1927(d)(2) of the Social Security Act, and while a proposed CMS reinterpretation and a CMMI pilot program announced in 2025 represent incremental progress[9], no statutory fix has been enacted and millions of Medicare beneficiaries remain without reliable access to FDA-approved anti-obesity medications; and

Whereas, only approximately 25 states have implemented some form of taxpayer-funded coverage for anti-obesity medications[10], and coverage in the ACA individual and small-group marketplace remains virtually nonexistent, with fewer than 1% of plans covering GLP-1 receptor agonists for weight management as of 2024[11]; and

Whereas, utilization of anti-obesity medications among eligible individuals is estimated at only 0.5% overall and 0.27% among individuals from historically underserved populations[8], demonstrating a significant access gap that disproportionately affects communities of color, rural populations, and those with lower socioeconomic status; and

Whereas, bariatric and metabolic surgery remains severely underutilized, with fewer than 1% of eligible patients receiving surgery[12], due in part to burdensome prior authorization requirements and exclusionary insurance plan design; and

Whereas, a 2024 AMA survey found that 93% of physicians reported that prior authorization delays patients' access to necessary care[13], with practices completing an average of 39 prior authorization requests per physician per week, imposing a particularly acute burden in the treatment of obesity; and

Whereas, some insurers terminate coverage of obesity treatments when a patient's BMI improves below a threshold, which is clinically analogous to discontinuing insulin when hemoglobin A1c normalizes and fundamentally contradicts the AMA's recognition of obesity as a chronic disease requiring ongoing management[14]; and

Whereas, no other chronic disease recognized by the AMA, including hypertension, type 2 diabetes, or hyperlipidemia, is subject to comparable systematic exclusion from insurance coverage or to the requirement that patients demonstrate failure of lifestyle modification before receiving pharmacologic or procedural treatment[15]; and

Whereas, the continued rise in obesity prevalence since 2013, combined with persistently low utilization of evidence-based treatments across all modalities, indicates that existing policy has not yet achieved the systemic changes necessary to close the gap between the AMA's recognition of obesity as a chronic disease and equitable patient access to treatment; therefore be it

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease, without exclusionary carve-outs, annual or lifetime caps specific to obesity, or "fail first"/step therapy requirements not applied to comparable chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of anti-obesity medications (Section 1927(d)(2) of the Social Security Act), and further advocate that all state Medicaid programs be required to include FDA-approved anti-obesity medications on their formularies as a condition of federal matching funds (Directive to Take Action); and be it further

RESOLVED**,** that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage for evidence-based obesity treatment on insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-440.842 Recognition of Obesity as a Disease H-440.842

Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
Res. 420, A-13, Reaffirmed: CSAPH Rep. 08, A-23

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis

1. Our American Medical Association will advocate for the creation of a multidisciplinary federal task force, including representation from the medical profession, to review the public health impact of obesity and recommend measures to:
    a. Better recognize and treat obesity as a chronic disease.
    b. Confront the epidemic of obesity and its root causes, particularly among populations with disproportionally high incidence.

2. Our AMA will actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month".
3. Our AMA will strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention.
4. Our AMA will promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula.
5. Our AMA will make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
6. Our AMA elevates obesity to be one of its public health priorities.

Res. 405, A-03; Reaffirmation, A-04; Reaffirmation, A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified – BOT, Action in response to referred for decision: Res. 403, A-21; Appended: Res. 427, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-26)

Introduced by: Ohio

Subject: Oppose Denials Based on Origin of Referral

Referred to: Reference Committee G

Whereas, patients may see another clinician in a primary care group for an acute problem or visit; and

Whereas, referrals may be made by multiple members of a care team; and

Whereas, denials for surgery are happening when the referring clinician does not match the primary care clinician listed with the insurer; and

Whereas, the medical necessity or timeliness is irrelevant to the approval; and

Whereas, denials delay care and harm patients; therefore be it

RESOLVED, that our American Medical Association advocate against prior authorization denials based solely upon the referring physician or appropriately licensed clinician. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-26)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, Society for Investigative Dermatology

Subject: Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions

Referred to: Reference Committee G

Whereas, employed physicians now often find themselves under substantial pressure to meet benchmarks and productivity targets established by hospitals, health systems, and other physician employers; and

Whereas, relentless focus on productivity metrics has been associated with physician burnout, emotional exhaustion, moral distress, and workforce attrition, all of which may threaten patient access to timely, high-quality care; and

Whereas, many commonly used productivity systems and metrics emphasize quantifiable outputs while underrecognizing the substantial administrative, educational, and operational work, as well as other essential responsibilities, that physicians are expected to perform for hospitals, health systems, and other employers that rely on and benefit from these contributions; and

Whereas, such work may include in-basket management, care coordination, quality reporting, teaching, research, administrative leadership, supervision, and other activities that are essential to patient care delivery but may not be fully reflected in physician productivity benchmarks, creating tension between institutional productivity expectations and physicians' broader professional obligations as employed clinicians; and

Whereas, increasing pressure to meet productivity benchmarks has occurred at the same time as expanding clinical and administrative demands, often without corresponding physician time, support, or recognition; and

Whereas, physician workforce sustainability and patient access are better supported when physician expectations and performance assessments more accurately reflect the full scope of work required in modern medical practice; therefore be it

RESOLVED, that our American Medical Association advocate that health systems, hospitals, other physician employers, and third-party payors recognize that the profession of medicine is not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and should not be reduced solely to productivity measures (Directive to Take Action); and be it further

RESOLVED that our AMA encourage employers of physicians to utilize productivity benchmarks, performance expectations, and compensation structures that recognize and integrate the full scope of physician work, including clinical, administrative, educational, and

operational responsibilities that may not be fully captured by traditional productivity metrics (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide both employed and independent physicians with appropriate time, resources, compensation, support, and recognition for non-billable work that is essential to patient care, physician well-being, and health system function. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

RELEVANT AMA POLICY

D-400.982 AMA Efforts on Medicare Payment Reform
1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.
[BOT Rep. 12, A-24 Reaffirmed: Res. 220, I-24]

D-385.945 Advocacy and Action for a Sustainable Medical Care System
1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.
[Res. 214, A-23 Reaffirmed in lieu of: Res. 225, A-25]

D-400.981 Increasing Transparency of AMA Medicare Payment Reform Strategy
1. Our American Medical Association will provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.
2. Our AMA will share with its members comprehensive reports on
our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.
[Res. 233, A-25]

D-310.968 Physician and Medical Student Burnout
1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow,

and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
1. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
2. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
3. Our AMA supports physicians who are caregivers to alleviate physician burnout.
[CME Rep. 8, A-07 Modified: Res. 919, I-11 Modified: BOT Rep. 15, A-19 Reaffirmation: A-22 Reaffirmed: Res. 802, I-24 Appended: Res. 305, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-26)

Introduced by: North American Neuromodulation Society

Subject: Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies

Referred to: Reference Committee G

Whereas, chronic pain affects approximately 20% of adults in the United States and represents a leading cause of disability and healthcare utilization[1]; and

Whereas, neuromodulation therapies, including peripheral nerve stimulation, spinal cord stimulation, and other device-based interventions, are evidence-based, minimally invasive, non-opioid treatment options for chronic nociceptive and neuropathic pain[2,3]; and

Whereas, timely initiation of neuromodulation therapies is critical to achieving optimal clinical outcomes, particularly for therapies designed to modulate neural circuits early in the disease course[4]; and

Whereas, prior authorization requirements imposed by insurance providers frequently result in delays in access to medically necessary, evidence-based pain treatments[5]; and

Whereas, a prospective multicenter observational cohort study of patients undergoing temporary peripheral nerve stimulation demonstrated that insurance authorization delays were independently associated with reduced odds of achieving clinically meaningful pain relief at both 60 days and 12 months[6]; and

Whereas, increasing delays in authorization were associated with progressively lower treatment response rates, even after adjustment for demographic and clinical variables[6]; and

Whereas, administrative delays in care are associated with worsened patient outcomes, prolonged disability, and increased reliance on less effective or higher-risk treatments, including opioids[7]; and

Whereas, variability in payer coverage policies, including recent updates by Aetna to provide national coverage for select neuromodulation therapies, highlights an inconsistent and evolving reimbursement landscape across insurers[8,9]; and

Whereas, inconsistent prior authorization requirements across payers contribute to inequities in access to evidence-based, non-opioid pain treatments; therefore be it

RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior authorization processes across payers, including response timelines that do not exceed 72

hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and be it further

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/15/26

REFERENCES

1. Dahlhamer J, Lucas J, Zelaya C, et al. Prevalence of chronic pain and high-impact chronic pain among adults-United States, 2016. MMWR. 2018;67(36):1001-1006.
2. Deer TR, Pope JE, Hayek SM, et al. The Neurostimulation Appropriateness Consensus Committee (NACC) recommendations for neuromodulation. Neuromodulation. 2020;23(1):1-20.
3. North RB, Shipley J, Prager J, et al. Practice parameters for the use of spinal cord stimulation in chronic pain. Pain Med. 2021.
4. Gilmore CA, Ilfeld BM, Rosenow JM, et al. Percutaneous peripheral nerve stimulation for chronic pain: prospective multicenter study. Pain Med. 2019;20(4):708-716.
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6. Yoo S, Lartigue S, Mtanes C, Odonkor CA. Tick Tock: How Insurance Authorization Delays May Impact 60-day Peripheral Nerve Stimulation Outcomes. Prospective multicenter cohort study.
7. Resneck JS Jr, et al. Burden of prior authorization on patient care and physician practice. JAMA. 2021;326(5):429-430.
8. Aetna. Clinical Policy Bulletin: Electrical Stimulation for Pain (CPB 0011). Available at: https://www.aetna.com/cpb/medical/data/1_99/0011.html
9. SPR Therapeutics. SPRINT PNS System Now Covered Nationally by Aetna. GlobeNewswire. March 13, 2026.

RELEVANT AMA POLICY

D-320.970 Advocating Against Prior Authorization for In-Person Visits with Physicians
Our AMA advocates against health insurance plan policies that require prior authorization for in-person visits with a physician. [Res. 708, A-25]

H-320.939 Prior Authorization and Utilization Management Reform
Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the

extent to which these processes contribute to patient harm. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. [CMS Rep. 08, A-17; Reaffirmation I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation A-22]

H-120.988 Patient Access to Treatments Prescribed by Their Physicians
Our American Medical Association confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified: CSA Rep. 3, A-97; Reaffirmed and Modified: Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23; Reaffirmed: CSAPH Rep. 02, A-24]

H-120.922 Improved Access and Coverage to Non-Opioid Modalities to Address Pain
Our American Medical Association will advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient’s physician. Our AMA will advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and Our AMA will encourage the manufacturers of pharmaceutical pain care options to seek United States Food and Drug Administration approval for additional indications related to non-opioid pain management therapy. [Res. 218, A-19; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: Res. 830, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Physician Case Log Portability

Referred to: Reference Committee G

Whereas, physician case logs documenting clinical encounters and procedures are routinely required for medical licensure, hospital credentialing, and the obtainment and renewal of hospital clinical privileges; and

Whereas, hospitals, billing companies, management groups, and health systems typically maintain exclusive custody and control of physician case logs through proprietary medical record systems; and

Whereas, advances in health information technology permit rapid, secure, and reliable deidentification of patient information in compliances with federal privacy standards; and

Whereas, delay or refusal to release physician case logs can delay or prevent a physician from obtaining licensure and employment; and

Whereas, such delays disproportionately affect physicians leaving unsafe and unethical work environments which further impairs physician well-being; and

Whereas, delays in credentialing and privileging result in measurable economic harm to physicians; and

Whereas, there is currently no uniform, enforceable national standard governing timelines, format, and remedies for the release of physician case logs; therefore be it

RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further

RESOLVED, that such polices establish a mandatory and enforceable timeline for production of case logs, not to exceed five (5) business days (Directive to Take Action); and be it further

RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA

Referred to: Reference Committee G

Whereas, the AMA General Counsel acknowledged that the AMA members are free to advocate for any issue as they wish, and the House of Delegates is free to pass policy that serves the physician interests; and

Whereas, virtual credit cards are a perennial problem to physician practices, causing significant administrative burnout and imposing high costs, collectively greater than $10 billion per year; and

Whereas, virtual credit cards have not been adopted as a legal payment method for health plans to make electronic payments to physicians under HIPAA and their status is at best legally contested; and

Whereas, the Centers for Medicare and Medicaid Services (CMS), under lobbying from the virtual credit card industry including Mastercard and Zelis, decided to take a contested position advocated by Mastercard and UnitedHealthcare Vpay that virtual credit cards are a legal way for paying physicians by health plans, however CMS has never promulgated a proposed rule under the Administrative Procedure Act to promulgate such policy as required by law; and

Whereas, CMS, incredulously and contrary to the law and under lobbying from Zelis, United Healthcare Optum Vpay, Echohealth, and Mastercard took the position that even as the law states that physicians are entitled to get healthcare payments via the adopted standard no-cost ACH EFT, CMS decided that health plans are free to send the first payment through non-standard electronic payment formats; and

Whereas, health plans allegedly coordinate with virtual credit card industry vendors to require fees from physicians for getting paid by ACH EFT, a federally recognized low-cost payment method, but CMS accepted vendor arguments that vendors can impose administrative costs on physicians by forcing physicians to fill out the same form 700 times to enroll in the same electronic transaction for every plan that is administered by virtual credit card companies or pay 2.5 percent of revenue while HIPAA mandates lowering administrative costs; and

Whereas, for any legally unsettled and contested issue, the American Medical Association is legally free to take a position that is most favorable to its members and the legality of virtual credit cards is such an issue; therefore be it

RESOLVED, that our American Medical Association will advocate that a vendor or clearinghouse that offers a multi-payer platform may not create separate payer-specific enrollment mechanisms into standard adopted HIPAA transactions (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic transactions that unnecessarily create duplicate administrative work for physician practices by creating a separate mechanism of enrollment in the same standard transaction for different health plans. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. Madara, James. (June 6, 2025). [AMA comment letter to CMS Administrator Mehmet Oz regarding "Unleashing Prosperity Through Degregulation of the Medicare Program (Executive Order 14192) – Request for Information"]. AMA federal and state correspondence finder.
2. Whyte, John. (July 10, 2025). [AMA comment letter to Health and Human Services Secretary Robert F. Kennedy, Jr regarding "Ensuring Lawful Regulation and Unleashing Innovation to Make American Healthy Again – Request for Information"]. AMA federal and state correspondence finder.

RELEVANT AMA POLICY

Virtual Credit Card Payments H-190.955

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Citation: Sub. Res. 714, A-15; Reaffirmed: BOT Rep. 09, A-25

Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS D-190.965

Our American Medical Association will report at the Annual 2026 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968.

Citation: Res. 819, I-25

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:
    a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
    b. CMS enforcement activities related to this issue.
    c. Physician access to a timely no fee EFT option as an alternative to VCCs.

Citation: Res. 819, I-23

CMS Administrative Requirements D-190.970

1. Our American Medical Association will forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA).
2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees.
3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.
4. Our AMA will through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.
   Citation: Res. 229, I-21; Reaffirmed: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Equal Opportunity for Payment for "On Call" Duty

Referred to: Reference Committee G

Whereas, a primary goal of the American Medical Association is enhancing the satisfaction and sustainability of medical practice; and

Whereas, traditionally, physicians were expected to be "on call" to the hospital for a minimum amount of time as a responsibility of being on the medical staff, but in recent decades, the shift to employing many physicians by a hospital included coverage duties which by definition is paid as a part of the salary of the employed physician; and

Whereas, additionally, some independent physicians are paid for "on call" duties to ensure access to a given specialty, yet others (not in short supply) are not[1]; and

Whereas, the duty to be "on call" for consultation at the hospital carries an opportunity cost of being unable to schedule or participate in other activities, quite apart from any patient care that may eventuate; and

Whereas, the independent physician may bill for direct patient care, but that does not cover the opportunity cost of simply being "on call;" and

Whereas, in at least one state (Massachusetts), that the nature of the relationship of the physician to the institution has changed in recent decades is acknowledged by policy ratified by the Massachusetts Medical Society that advocates that "hospitals engage community/independent specialty physicians on the medical staff for observation, inpatient and emergency department coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service"[2]; and

Whereas, guidelines for such negotiation start with equitable payment for service; therefore be it

RESOLVED, that our American Medical Association will work with relevant stakeholders to advocate that all physicians, whether employed or independent, should be paid for "on call" responsibilities, whether or not patient care is separately billed. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/26

REFERENCES

1. Nabity, J. (2021). Your full guide to on-call pay for physicians. *Physicians Thrive*. https://physiciansthrive.com/physician-compensation/on-call-pay-physicians/
2. Massachusetts Medical Society. (2024). *MMS Policy Compendium*. https://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Policy-Compendium-(pdf)/

RELEVANT AMA POLICY

On-Call Physicians H-130.948

Our AMA:
(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.
Citation: CMS Rep. 3, I-99; Reaffirmed: A-00; Modified: Sub. Res. 217, I-00; Reaffirmed: I-01; Reaffirmed: A-07; Appended and Reaffirmed: CMS Rep. 1, I-09; Modified: Res. 818, I-17

On-Call Coverage Models D-130.965
Our American Medical Association will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands, and educate AMA physician members regarding these options.
Citation: Res. 722, A-13; Reaffirmed: CMS Rep. 01, A-23

On-Call and Emergency Services Pay D-130.963
Our AMA will develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.
Citation: Res. 818, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

Referred to: Reference Committee G

Whereas, the United States healthcare system is complex with over 2.5 million ERISA-covered group plans in 2021 according to the U.S. Department of Labor, plus over 4,000 Medicare Advantage and Medicaid managed care plans and even more venders connecting to more than one million physician practices and other provider in 1-to-1 connections making automation neither possible nor feasible; and

Whereas, health plan identifiers (HPID), a standardized national identifier for each of the greater than 2.5 million health plans was mandated by HIPAA but never implemented causing numerous administrative problems, including the inability of the Centers for Medicaid and Medicare Services (CMS) to administer the No Surprises Act and confusion as to who is getting healthcare claims and who is paying with a health plan such as Kaiser Permanente having up to five different payer IDs for the same plan, pending on the clearinghouse used; and

Whereas, true interoperability at scale is impossible with standardization and a unique health plan ID; and

Whereas, the AMA has existing policy ("Promoting Electronic Data Interchange" H-190.978) that calls for a national electronic transaction clearinghouse that "continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronic claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange;" and

Whereas, for the CMS Prior Authorization rule, CMS advised that healthcare providers pull out their rotary phones to "connect electronically to health plans," an insane idea for implementation of a modern interconnectivity technology; therefore be it

RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain only one standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier such as a health plan identifier (HPID) and/or national provider identifier (NPI). (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. Centers for Medicare and Medicaid Services. *HPID*. Department of Health and Human Services. https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/unique-identifiers/hpid. Accessed April 7, 2026.

RELEVANT AMA POLICY

Promoting Electronic Data Interchange H-190.978

1. Our American Medical Association:
    1. adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing:
        a. Public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice.
        b. Vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry).
        c. Vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim.
        d. All clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers).
        e. Practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products.
        f. States should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims.
        g. Federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that:
            i. any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations.
            ii. that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services.
2. continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing.
3. continues to explore EDI-related business opportunities.
4. continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange.
5. continues its leadership roles in the NUCC and WEDI.
6. through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.

Citation: BOT Rep. 9, A-96, Amended: CMS Rep. TT, I-96; Appended: Sub. Res. 702, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: I-13; Reaffirmed: A-22

Administrative Simplification in the Physician Practice D-190.974

1. Our American Medical Association strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19; Reaffirmed: A-22

Informational Reports (A-26)

Report(s) of the Board of Trustees

03 2025 Grants and Donations
05 Update on Corporate Relationships
06 AMA Performance, Activities and Status in 2025
07 Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026
09 American Medical Association Optimal Health Outcomes Annual Report
10 AMA Efforts on Medicare Payment Reform
11 AMA Public Health Strategy Update
16 Demographic Report of the House of Delegates and AMA Membership
18 Report on the Preservation of Independent Medical Practice
26 AMA Ethics Fellowships
30 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
31 Establishing an Advisory Committee on AI/AN Affairs
32 Disability Advisory Group
33 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Report(s) of the Council on Constitution and Bylaws

01 Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates

Report(s) of the Council on Ethical and Judicial Affairs

04 Carceral Systems and Practices in Behavioral Health Emergency Care
06 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Opinion(s) of the Council on Ethical and Judicial Affairs

01 Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
02 Research Involving Pregnant and Lactating Individuals

Report(s) of the Council on Medical Service

02 Study of the Federal Employees Health Benefits Program (FEHBP)

REPORT OF THE BOARD OF TRUSTEES

BOT Report 03-A-26

Subject: 2025 Grants and Donations

Presented by: David H. Aizuss, MD, Chair

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

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

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	$ 44
Centers for Disease Control and Prevention	Project Firstline: Improving Infection Control Capacity for Frontline Adult-Care Clinicians	1,060
Centers for Disease Control and Prevention	Prevention Rx: Engaging Physicians to Enhance Public Health	1,243
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System - Medications for Opioid Use Disorders	9
Government Funding		**2,356**
American Heart Association	International Congress On Peer Review and Scientific Publication	10
American Medical Association Foundation	Health Equity Acceleration Fund	978
American Medical Association Foundation (supported by Robert Wood Johnson Foundation funding)	The Truth, Reconciliation, Healing, and Transformation Project	198
American Society of Hematology	International Congress On Peer Review and Scientific Publication	10
Institute of Electrical and Electronics Engineers, Inc.	International Congress On Peer Review and Scientific Publication	20
Massachusetts Medical Society	International Congress On Peer Review and Scientific Publication	20
The Physicians Foundation	American Conference on Physician Health	20
Nonprofit Contributors		**1,256**
Elsevier B.V.	International Congress On Peer Review and Scientific Publication	10
MPS Limited	International Congress On Peer Review and Scientific Publication	10
Silverchair Science + Communications, LLC.	International Congress On Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress On Peer Review and Scientific Publication	20
Contributors less than $5,000	International Medical Graduates Section Reception	4
Other Contributors		**54**
Total Grants and Donations		**$ 3,666**

REPORT OF THE BOARD OF TRUSTEES

BOT Report 05-A-26

Subject: Update on Corporate Relationships

Presented by: David H. Aizuss, MD, Chair

PURPOSE

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

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

BACKGROUND

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

YEAR 2025 RESULTS

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

CONCLUSION

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

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

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

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

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

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

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

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

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

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

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2025

CONFERENCES/EVENTS

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

Project Number	Project Description	Corporations/Organizations	Approval Date
68242	**ViVE Sponsorships** – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	01/27/25
68282	**DeviceTalks Conference –** Sponsorship with VDL name and logo.	WTWH Media	01/31/25
68409	**Machine Learning for Healthcare Conference** – Repeat sponsorship with AMA name and logo.	Mayo Clinic Columbia Data Science Institute Columbia Vagelos College of Physicians and Surgeons Nihon-Kohden LLC Google Deep Mind New York Presbyterian Apple Microsoft Columbia University Johns Hopkins University Duke University	02/03/25
68313	**Becker's Collaborations -** CEO & CFO Roundtables and Virtual Event, White Paper and Annual Hospital Review with AMA name and logo.	Becker's Hospital Review ASC Communications	02/07/25
68402	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Blue Cross Blue Shield Foundation Pampers US Advanced Medical Technology Association Abbott Laboratories S&P Global	02/11/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68548	**Credentialing State Shows –** Repeat sponsorships with AMA name and logo.	Pennsylvania Association of Medical Staff Services Ohio Association Medical Staff Services Florida Association of Medical Staff Services California Association of Medical Staff Services Illinois Association of Medical Staff Services Wisconsin Association of Medical Staff Services New York State Association of Medical Staff Services Texas Society for Medical Services Specialists Tennessee Association of Medical Staff Services New Jersey State Association Medical Staff Services New Mexico Association of Medical Staff Services Georgia Association of Medical Staff Services Baton Health Edge-U-Cate The Greeley Company Hardenbergh Group HealthStream Hospitality Staffing Solutions MD Review MD Staff PennState Health Pennsylvania Medical Society PreCheck Provider Passport PRS Credentialing Services QGenda Symplr	02/14/25
68583	**AZARA User Conference** – Sponsorship with AMA MAP hypertension program name and logo.	Azara Healthcare Upstream USA	02/18/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68522	**AMA International Medical Graduates Section Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name.	Educational Commission on Foreign Medical Graduates	02/24/25
68703	**HealthStream Thrive25 Annual Conference –** Sponsorship with AMA name and logo.	HealthStream Hardenbergh Group American Board of Medical Specialties Evergreen Health Partners Axuall	02/26/25
68713	**IAIABC Forum and Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions Deloitte National Council on Compensation Insurance Optum AEG Worldwide The Black Car Fund Sedgwick HealtheSystems Enlyte Concentra SFM Mutual Insurance Official Disability Guidelines by MCG Health Safety National Guidewire Software Sapiens Insurance Software Wisedocs Eckler Ltd. WorkCompCentral Verisk	02/26/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68764	**Health Care Value Week Value-based Payment Summit -** Collaboration with AMA name and logo.	Accountable For Health America's Health Insurance Plans Blue Cross Blue Shield Association Alliance for Value-based Patient Care American Hospital Association American Medical Group Association America's Physician Groups Association for Behavioral Health and Wellness Better Medicare Alliance Healthcare Leadership Council Margolis Institute for Health Policy Healthcare Transformation Task Force Medical Group Management Association National Association of ACOs National Rural Health Association Paragon Health Institute Partnership to Empower Physician Led Care Population Health Alliance Premier, Inc.	02/27/25
68469	**National Medical Association Events–** Release the Pressure sponsorships of Colloquium and National Convention with RTP name and logo.	National Medical Association Pfizer Eli Lilly PennState Health Campaign for Tobacco Free Kids American Cancer Society Novo Nordisk Humana Biogen Ochsner Health Viiv Healthcare American Academy of Sleep Medicine Foundation American College of Obstetricians and Gynecologists GlaxoSmithKline Mayo Clinic Labcorp Howard University School of Medicine Yale School of Medicine	02/28/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68849	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	Asian American Journalists Association The Guardian CNN Axios Scripps Sinclair Nexstar American Heart Association American Association of Retired Persons Northwestern University American University	03/05/25
68883	**i2i Client Conference Sponsorship –** Sponsorship with AMA MAP hypertension program name and logo.	i2i Population Health MedTech Solution SyncTimes Labcorp ChartSpan Sonata Software OptMyCare Sisense	03/06/25
69187	**Chief Medical Officer Exchanges** – Repeat sponsorships with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Ambience Healthcare Microsoft SaVia Health Solventum Corporation	03/06/25
68863	**National Association of Hispanic Journalists Conference -** Repeat sponsorship with AMA name and logo.	National Association of Hispanic Journalists Robert Wood Johnson Foundation Cedars Sinai Children's Hospital Los Angeles California Health Care Foundation Big Cities Health Coalition Vital Strategies The Commonwealth Fund The John A. Hartford Foundation Patient Centered Outcomes Research Institute Blue Cross of California Foundation The Kresge Foundation Peterson Center on Healthcare The California Endowment	03/07/25

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

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

Project Number	Project Description	Corporations/Organizations	Approval Date
70260	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation Fenwick & West LLP Penner Family Foundation California Health Care Foundation CVS Health Ventures Peterson Health Technology Institute Pivotal Ventures PolicyMap Tulsa Innovation Labs Calm Meditation App Consulate General of Canada CareQuest HopeLab	05/11/25
70726	**CFHA Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Alliance Health Community Care of North Carolina American Psychological Association Concert Genetics EvolveMD Foundation for Health Leadership & Innovation Health Federation of Philadelphia Merakey Education National Register of Health Service Psychologists	05/16/25
70302	**IPPNW Congress –** Sponsorship with Journal of Ethics name and logo.	International Physicians for the Prevention of Nuclear War Japanese Physicians for Prevention of Nuclear War Hiroshima Prefectural Medical Association Nagasaki Prefectural Medical Association	05/16/25

Project Number	Project Description	Corporations/Organizations	Approval Date
71073	**Institute of Medicine of Chicago Leadership Awards –** Sponsorship with AMA name and logo.	Institute of Medicine Golden Square Association Services Washington Square Health Foundation Johnson & Johnson Hektoen Institute Novo Nordisk Canon USA University of Illinois Health Golz LLC Family Christian Health Center The Portes Foundation	06/02/25
71171	**SAWCA Convention and Luncheon** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators AKERA Claims Solutions American International Group Ametros CompTrust Mutual Insurance Company Concentra Enlyte FAIR Health Healthesystems Meridian Wealth Management National Council on Compensation Insurance ODG by MCG Health Occupational Managed Care Alliance Optum Inc Safety National Casualty Company Sedgwick Trean Corporation Verisk Workers' Compensation Institute	06/09/25
71226	**AAMC Annual Meeting –** Sponsorship with Journal of Ethics name and logo.	Association of American Medical Colleges Elentra Elsevier ECG Management Consultants CU Medicine Colorado Resiliency Arts Lab MGM Resorts	06/16/25
71252	**Greenway ENGAGE Client Summit** – Repeat sponsorship with AMA name and logo.	Greenway Health HealthAsyst Phreesia Inc RevSpring Inc Rivet Health Solventum Corporation	06/23/25

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

Project Number	Project Description	Corporations/Organizations	Approval Date
72796	**Congressional Black Caucus Foundation Phoenix Awards Dinner** – Sponsorship with AMA name and logo.	Congressional Black Caucus Foundation	09/03/25
72324	**Association of American Indians Physicians 53rd Annual Meeting** – Sponsorship with AMA name and logo.	Association of American Indians Physicians National COVID-19 Resiliency Network at the Morehouse School of Medicine Opioid Response Network University of Utah Center for Native Excellence and Tribal Engagement American Association of Retired Persons Johnson & Johnson Deloitte Sacred Circle Healthcare Health Division of the Confederated Tribes of the Goshute Reservation Physicians Committee for Responsible Medicine	08/08/25
72731	**AGMB Conference** – Sponsorship with JAMA Network name and logo.	German Medical Library Association (AGMB) Elsevier Karger Publishers Frontiers Publishing Springer Nature EBSCO	09/03/25
73079	**HLTH Conference** - Repeat sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	09/17/25
73235	**MD-Staff Educational Conference Sponsorship** – Repeat sponsorship with AMA name and logo.	PreCheck ABMS Solutions The Greeley Company Hardenbergh Group	09/29/25
73773	**National Hispanic Health Foundation Scholarship Gala** – Sponsorship with AMA name and logo.	National Hispanic Health Foundation Eli Lilly Pfizer United Health Foundation Immune Deficiency Foundation Indiana University School of Public Health	10/15/25

Project Number	Project Description	Corporations/Organizations	Approval Date
73898	**South by Southwest MedTalk Conference** – Repeat sponsorship with AMA name and logo.	South by Southwest RIVIAN DirecTV Austin Convention Center Eventbase Technology Improvado Marketing AI Media	10/24/25
73897	**AIMed Conference –** Sponsorship with AMA name and logo.	AdventHealth Amazon Warehouse Services FPT Software Bayer Kaiser Permanente Institute for Medical Education Kore AI Mayo Clinic Platform Regional One Health Valid AI	10/24/25
73030	**HealthLeaders Chief Executive Officer Exchange –** Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders	10/31/25
74455	**Anarcha, Lucy, Betsey Annual Conference** – Repeat sponsorship with AMA name and logo.	Faith Crusade Montgomery Rescue Mission Robert Wood Johnson Foundation Every Mother Counts	11/19/2025
74501	**STFM Conference on Medical Student Education –** Sponsorship with AMA name and logo.	Society of Teachers of Family Medicine	11/24/25
74808	**MIT AI Conference –** Sponsorship with AMA name and logo.	MIT Critical Data Lab MIT Industry Liaison Program	12/09/25

Project Number	Project Description	Corporations/Organizations	Approval Date
75147	**HIMSS Global Health Conference & Exhibition –** Repeat sponsorship with AMA name and logo.	Healthcare Information Management Systems Society Elsevier Dedalus Italia S.P.A	12/22/25

EDUCATIONAL CONTENT OR GRANT

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

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

COLLABORATIONS/AFFILIATIONS

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

Project Number	Project Description	Corporations/Organizations	Approval Date
66537	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	St. Jude Children's Research Hospital The Medical College of Wisconsin Department of Anesthesiology Trinity Health Livonia University of Minnesota Physicians UT Health San Antonio Physicians UVA Health Wisconsin Northern and Central General Medical Education Consortium	01/08/25
68141	**Medbiquitous Collaboration –** Collaboration on data standards development with AMA name and logo.	Medbiquitous Association of American Medical Colleges	01/23/25
68323	**Healthcare Professional Gun Violence Campaign –** Collaboration with AMA name and logo.	Ad Council	02/06/25
68550	**Prevention Strategy Collaboration with Health Care Organizations –** Update to diabetes prevention program with AMA name and logo.	Community Health Center of Cape Cod Legacy Community Health Center Duncan Regional Hospital CommunityHealth	02/12/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68516	**Agree-to-Agree Youth Gun Violence Prevention Campaign –** Collaboration with AMA name and logo.	Ad Council AYA Healthcare BJC Health System Children's Hospital Association Dartmouth Health Dartmouth Children's Health Endeavor Health Froedtert Health Hackensack Meridian Health Intermountain Health Johns Hopkins Medicine Kaiser Permanente Levi Strauss & Company LifeBridge Health MedStar Health Michigan Health Northwell Health OhioHealth University of Michigan Yale New Haven Health	02/13/25
68650	**Target BP Promotional Video –** Collaboration with AMA name and logo.	American Heart Association Primary Care Associates of Appleton Heart of Ohio Family Health Chinatown Service Center	02/19/25
68582	**American Medical Group Association –** Sponsorship with AMA name and logo.	American Medical Group Association Abbvie Boehringer Ingelheim Dynavex Epic Indivior Magmutual Insurance Medallion Navina AI Microsoft Nuance PatientPoint PointClickCare The Kinetix Group The Partners Group Vatica Health	02/19/25

Project Number	Project Description	Corporations/Organizations	Approval Date
68707	**American Telemedicine Association –** Repeat sponsorship with AMA name and logo.	American Telemedicine Association Microsoft Intel eMed TeleHealth CDW Healthcare Abbott Novartis Optum Cigna Mayo Clinic Trinity Health American Hospital Association American Academy of Dermatology	02/28/25
68808	**Abortion Defense Network –** Collaboration with AMA name and logo.	Abortion Defense Network American College of Obstetrics & Gynecology Apiary for Practical Support The Forefront Project Gender Justice The Jane Network Legal Voice National Abortion Federation National Network of Abortion Funds Perkins Coie Physicians for Reproductive Health Pillsbury Winthrop Shaw Pittman LLP Planned Parenthood Pregnancy Justice Reproductive Equity Now Society for Maternal Fetal Medicine Society of Family Planning Women's Law Project	03/04/25
70355	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation American Association of Nurse Anesthesiology American Dental Association American Hospital Association American Nurses Association American Psychiatric Association Federation of State Physician Health Programs FIGS Heart of Safety Coalition Moral Injury of Healthcare Organizational Wellbeing Solutions	04/17/25

Project Number	Project Description	Corporations/Organizations	Approval Date
70613	**ACCME Journal of Graduate Medical Education "Reimagining Residency" Edition -** Collaboration with AMA name and logo.	Accreditation Council for Graduate Medical Education Journal of Graduate Medical Education	05/01/25
70551	**COVID-19 Monument of Honor, Remembrance, & Resilience –** Sponsorship of COVID healthcare worker memorial with AMA name and logo.	Hektoen Institute of Medicine Pfizer Illinois Medical District Commission Nephrology Association of Northern Illinois and Indiana Chicago Teachers Union Illinois Health and Hospital Association Fresenius Medical Care The Portes Foundation Illinois Federation of Teachers Strive Health Cook County Teachers Union North Star Investment Management United Food Commercial Workers	05/08/25
70781	**"A Guide to Collaborative Drug Therapy Management" –** Collaboration with AMA name and logo.	American College of Clinical Pharmacology	05/21/25
71006	**2025 Residency Guides** – Collaboration on medical resident guides with AMA name and logo.	Association of American Medical Colleges Organization of Program Directors Association	06/03/25

Project Number	Project Description	Corporations/Organizations	Approval Date
71130	**Joy in Medicine** – Repeat AMA recognition program for outstanding healthcare organizations.	Akron Children's Hospital Albany Medical Center Albany Medical College Ann & Robert H. Lurie Children's Hospital of Chicago BayCare Medical Group Bristol Health CarePoint Health CenterWell Senior Primary Care Central Ohio Primary Care Central Virginia VA Health Care System Children's Hospital Los Angeles Children's Specialty Group Cooperman Barnabas Medical Center Duly Health and Care Emory Healthcare Forefront Dermatology Houston Methodist Physician Organization Memorial Hermann Health System Minneapolis VA Health Care System Onvida Health Phoenix VA Health Care System Robert Wood Johnson University Hospital RWJBH Community Medical Center Sharp Rees-Stealy Medical Group Sutter Gould Medical Group Texas Valley Coastal Bend Veterans Healthcare System The Queen's Health Systems The University of Texas MD Anderson Cancer Center The University of Vermont Health Network UC San Diego Health University Health/Truman Medical Center University of California San Francisco Health University of Texas Southwestern Medical Center VA Boston Healthcare System VA Greater Los Angeles Healthcare System VA Palo Alto Health Care System Valley Medical Center Virtua Health	06/10/25

Project Number	Project Description	Corporations/Organizations	Approval Date
71657	**JAMA Network Worldwide –** Updated content agreement for online reference service with AMA name and logo.	USACO Corporation	07/17/25
71357	**The Naloxone Project –** Co-branded information brief for healthcare workers with AMA name and logo.	The Naloxone Project	07/21/25
71560	**Emergency Care for Pregnant Patients –** Collaboration to create guidance document with AMA name.	American College of Obstetricians and Gynecologists Society for Maternal Fetal Medicine Lawyers for Good Government	07/23/25
72225	**"Brother to Brother" Campaign and Maternal Health Roundtable** – Collaboration on heart and maternal health campaigns with RTP name and logo.	Association of Black Cardiologists	08/07/25
72679	**AMA Annual Research Challenge** – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	08/28/25
73018	**Mental Health Parity Collaboration –** Rollout of online tool comparing insurance mental health coverage, with AMA name and logo.	The Kennedy Forum The Ballmer Group New York Community Trust The Arthur M. Blank Foundation Third Horizon Strategies InterKnowlogy American Psychological Foundation Utilization Review Accreditation Commission	09/16/25
73027	**"What Doctors Wish Patients Knew" series –** Cobranded articles with AMA name and logo.	HCA Healthcare	09/25/25

Project Number	Project Description	Corporations/Organizations	Approval Date
73526	**Health Care Payment Policy Insights Report** - Report with AMA name and logo.	Alliance for Health Policy	10/06/25
73993	**Elsevier Publishing –** Collaboration on textbook with AMA name and logo.	Elsevier	11/14/2025
74666	**Leadership Council for Healthier Communities –** Sponsorship with AMA name and logo.	Creating Healthier Communities Ameriprise Financial Fulcrum Therapeutics Urban Institute Johns Hopkins University The Samaritan Health Project, Inc. Archstone Foundation PK Management Clear Horizon Group American Psychiatric Association Foundation Porter Novelli Health by Design JLL Real Estate Association of American Medical Colleges	11/20/2025
74667	**iHeart Media –** Podcast series with AMA name and logo.	iHeartMedia iHeartPodcasts iHeart Ignite	12/04/25
74338	**Federation of State Physician Health Programs –** Repeat **s**ponsorship with AMA name and logo.	Federation of State Physician Health Programs American Board of Medical Specialties Copic Insurance Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	12/06/25
75082	**The Health Management Academy –** Sponsorship with AMA name and logo.	The Health Management Academy	12/19/25

MEMBER PROGRAMS

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

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations/Organizations	Approval Date
69233	**Official Disability Guidelines (ODG by MCG) –** Licensing of AMA Guides to Permanent Impairment content for ODG by MCG platform with use of AMA Guides name and logo.	MCG Health	03/18/25
69292	**QGenda -** Licensing agreement for AMA VeriCre product with AMA name and logo.	QGenda LLC	03/19/25
70183	**OpenEvidence –** JAMA Network content licensing agreement with JAMA Network name and logo.	Open Evidence Inc	04/25/25
71244	**Validic** – Content licensing agreement with AMA MAP hypertension name and logo.	Validic Inc	06/25/25
71405	**Cedaron -** AMA Guides to Permanent Impairment content licensing agreement with AMA Guides name and logo.	Cedaron	07/15/25
73591	**ResearchGate -** JAMA Network content licensing agreement with JAMA Network name and logo.	ResearchGate	10/14/25
74378	**Symplr -** Licensing agreement for AMA VeriCre product with AMA name and logo.	Symplr	11/21/25

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-26

Subject: AMA Performance, Activities and Status in 2025

Presented by: David H. Aizuss, MD, Chair

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

INTRODUCTION

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

Amplifying physician voices and shaping policy

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

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

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

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

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

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

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

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

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

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

Driving the future of medicine

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

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

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

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

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

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

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

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

- 4.6 million visitor sessions
- 750,000 courses completed

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

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

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

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

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

Removing obstacles that interfere with patient care

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

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

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

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

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

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

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

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

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

Leading the charge to improve health outcomes

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

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

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

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

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

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

Membership

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

EVP Compensation

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

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

During 2025, pursuant to his employment agreement, total cash compensation paid to John J. Whyte, MD included $787,500 in salary and a $150,000 sign-on bonus, reduced by $6,204 in pre-tax deductions. Other taxable amounts per the contract were as follows: $2,860 imputed earnings for life insurance, $525 for a cell phone stipend, $1,820 paid for parking. $1,458 paid for health club dues and $11,686 for travel expenses to and from the Chicago office. Dr. Whyte's employment began on June 1, 2025.

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 07-A-26

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026

Presented by: David H. Aizuss, MD, Chair

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

TOBACCO USE AT A GLANCE

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

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

Adult Tobacco Use

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

cigarettes, compared to 21.6% of adults aged 25-44 years and 11.3% of adults aged 45-64 years.[11]

Youth Tobacco Use

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

Effects of Tobacco Use

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

NOTABLE FEDERAL ADMINISTRATIVE ACTIONS

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

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

On April 1, 2025, a significant number of staff at the U.S. Food and Drug Administration (FDA)'s Center for Tobacco Products (CTP) were terminated or otherwise removed.[29] The CTP oversees the implementation of the Family Smoking Prevention and Tobacco Control Act and is entirely funded by tobacco industry user fees.[30,31] Some of CTP's responsibilities include setting performance standards, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.[32] While some staff have been rehired, the restructuring has reduced the

Center's capacity to enforce tobacco restrictions and thoroughly review tobacco product applications.[33,34] Furthermore, several actions from the Center for Tobacco Products actions will facilitate easier access to tobacco and nicotine products in the U.S. including: (1) authorizing the sale of 20 different Zyn products, (2) setting up a fast-track review process for premarket tobacco applications for nicotine pouches and (3) authorizing additional menthol flavored e-cigarettes for sale.[35]

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

EFFORTS TO ADDRESS TOBACCO CONTROL

Changes to State Cigarette Taxes

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

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

Funding for State Tobacco Prevention and Cessation Programs

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

AMA LITIGATION CENTER

The AMA Litigation Center continues to be active in state and federal courts around the country in matters involving tobacco control and regulation of flavored electronic nicotine delivery systems (ENDS). In April 2025, the United States Supreme Court issued a favorable decision in *FDA v. Wages and White Lion Investments*, which reversed a Fifth U.S. Circuit Court of Appeals ruling in favor of ENDS manufacturers and sellers. If the Court upheld the lower court

ruling, companies could have marketed products that were clearly designed to appeal to children, with names such as “Jimmy the Juice Man Peachy Strawberry”, “Suicide Bunny Mother’s Milk and Cookies”, “Pink Lemonade”, “Iced Pineapple Express” and “Killer Kustard Blueberry.” The FDA had denied the companies’ applications for premarket approval of the tobacco products. The companies challenged the agency’s decision, arguing that the FDA did not give them fair notice about the evidentiary and comparative requirements used during the application stage and that the agency had changed its position on scientific evidence. The AMA joined several Federation members and anti-smoking partners in a brief explaining the harm caused by these products. The brief urged the court to conclude that the FDA was correct in how it determined that the companies should not be able to market the flavored e-cigarette liquids. The Supreme Court ruled that the FDA did not act in an arbitrary and capricious manner when it denied the companies’ applications and remanded the case to the Fifth Circuit to review other legal arguments.

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

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

AMA ADVOCACY

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

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

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

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

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

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REPORT 9 OF THE BOARD OF TRUSTEES (A-26)
American Medical Association Optimal Health Outcomes Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates (HOD) adopted the recommendations of Policy D-180.981 directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 AMA Organizational Strategic Plan to Advance Health Equity in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." This report marks the seventh AMA Optimal Health Outcomes Report.

Discussion: The AMA has continued its efforts over recent years to further embed equity and improve health outcomes. The 2024-2025 iteration of the Plan served as a guide for the work. This report outlines the activities conducted by our AMA during calendar year 2025, divided into four pillars, demonstrating relevance, impact, and thought leadership: (1) Community Health Impact, (2) Health Systems Engagement, (3) Policy Development and (4) Data and Research.

Conclusion: This report highlights only a portion of the work accomplished and lessons learned in 2025. AMA staff have devoted countless hours to learning how they can collaborate in advancing health outcomes and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward improving health outcomes.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 09-A-26

Subject: American Medical Association Optimal Health Outcomes Annual Report

Presented by: David H. Aizuss, MD, Chair

BACKGROUND

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

DISCUSSION

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

Community Health Impact

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

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

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

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

populations that they were interested in serving upon the opening of their practices; a number of those in the program look to start their own practices to focus on underserved communities.

- AMA STEPS Forward® continued to hold events, reaching a wider audience of attendees, while maintaining discounted attendance for FQHCs and safety-net providers. The bootcamps offer evidence-based time management and team-based care strategies to provide quality patient care. In 2025, an updated STEPS Forward resource page was created to specifically guide and support FQHCs and safety-net providers on the AMA site.
- New STEPS Forward® content helped address determinants of health and differences in health outcomes. For example, 2025 STEPS Forward® podcast content included nine optimal health outcomes-related episodes, including (1) Screening for Prediabetes: Pearl of the Month, (2) How to Take a Patient-Centered Approach to Cancer Care, (3) Help for Patients with Uncontrolled Hypertension: Pearl of the Month, (4) One Federally Qualified Health Center's Journey to Joy in Medicine and (5) A Lifeline for Moms: Providing Whole Person Care in Maternal Health Settings.
- In 2025, the AMA content on optimal health outcomes experienced a 50 percent increase in engagement from 2024, reaching three million website users. The AMA completed 16 website accessibility improvements across its websites. As part of the AMA's efforts to complement and enhance physician professional development, the AMA launched the AMA Physician Education Program (PEP) to provide a flexible and robust continued learning experience specifically curated for physicians. Topics covered range from optimizing health outcomes, quality and safety, well-being, leadership development and more.
- On the AMA Ed Hub™ site, the AMA published 128 new optimal health outcomes-related activities and renewed 101, with user engagements reaching over 300,000. Notably, the AMA, in partnership with the Docs with Disabilities Initiative, completed filming for a nine-part webinar series titled *Caring for People with Disabilities* with publication on the AMA Ed Hub™ planned for 2026. Additionally, the AMA hosted the new podcast episode Microplastics Infiltrate Our Bodies: How Can Physicians Help? which explores the impact of microplastics on public health and reducing practice exposure to microplastics.
- Our AMA continued to follow the Enterprise Social Responsibility (ESR) team's community engagement framework to build meaningful relationships with local organizations. In 2025, the ESR team hosted 51 community engagement events across 16 community organizations, including Erie Neighborhood House, Gardeneers, MyBlock MyHood MyCity, Nourishing Hope, Imagine Englewood if, Pilsen Food Pantry and Cardz for Kidz. This year two new community partnerships were established with Growing Home and Project Linus to support their work to address the social determinants of health and move toward community health impact.
- The AMA offered internships and fellowships to various groups. As an example, AMA IT hosted 29 Chicago Public School high school student interns from historically underrepresented backgrounds and provided students with the opportunity to visit the AMA, engage with AMA IT professionals and learn about the AMA's history and its role in promoting national health and well-being. Additionally, the JAMA Network manuscript editing teams offered a summer medical editing internship designed for third- and fourth-year college students to gain exposure to medical editing and publishing as a career. The JAMA Editorial Fellowship Program also welcomed ten early career academic physicians and nurses in the fully remote fellowship program, intended to engage around editorial decision-making and enhance scientific communication skills. Lastly, the AMA continued the Summer Health Law Internship for a rising third-year law student, with a focus on differences in health outcomes and law.
- The AMA's Release the Pressure (RTP) campaign focused on addressing and improving heart health among those with the highest burden of hypertension by encouraging them to prioritize their blood pressure. The AMA Foundation, the Minority Health Institute, the National Medical Association (NMA), the American Heart Association (AHA), and the Association of Black

Cardiologists (ABC) were engaged through RTP. RTP had a presence at conferences and conventions, including the NMA Colloquium on African American Health and the Congressional Black Caucus Foundation's 54th Annual Legislative Conference, engaging over 113 physicians.

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

- Internally, our AMA supports initiatives to enhance employee experience, engagement and well-being, anchored in four strategic areas: (1) Foundational Infrastructure, (2) Access and Fairness, (3) Skills-Based Learning and (4) Inclusive Culture and Climate. In 2025, the AMA consulted an external vendor to conduct the 2025 Employee Engagement Survey to provide current insights into employee experience, including critical engagement index metrics. Results will guide strategies to improve inclusion outcomes.
- The AMA continues to foster inclusion and belonging across the organization through nine Employee Resource Groups (ERGs) that organize intersectional programming designed to advance inclusive learning, cultivate community, and support personal and professional development of members through the following events: book clubs, volunteering, panels, and professional development workshops. All ERGs are open to all employees.
- Staff continued to surpass their individual, voluntary learning goals, averaging more than 20 hours of flexible learning across related health topics in 2025. Within BUs, staff have led educational activities and events to strengthen community engagement and improve community health outcomes. For example, the AMA's Education Center held monthly learning sessions focused on optimal health outcomes and inclusion, offering over 15 hours toward individual learning goals. Additionally, the AMA's Health Solutions unit engaged in bias and engagement training which focused on employee inclusion. As part of this training, all staff completed a self-paced 90-minute course titled Breaking Bias Foundations from Be More with Anu. Furthermore, 19 AMA staff members also completed the three day in-person BRAVE leadership training that centers a trauma-responsive approach for leaders to enhance inclusion and retention of staff.

Health Systems Engagement

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

- The AMA and the American Heart Association (AHA) recognized nearly 2,400 organizations that committed to improving blood pressure control rates by submitting data to the 2025 Target: BP Achievement Awards. Over 38 million patients were served by 2,393 total eligible participating health care organizations across 49 U.S. states and territories.
- To advance improvements in maternal health, the AMA developed four new tools and resources to help health care organizations and clinical care teams improve blood pressure monitoring and management during pregnancy and postpartum period, including two AMA MAP HTN™ educational resources for patients and clinical teams.
- To advance the national Million Hearts campaign, the AMA, in partnership with the CDC and Alliance Chicago, engaged five Health Center Controlled Networks and 19 community health centers with an aim to prevent heart attacks and strokes in over 900,000 adult patients, with a focus on minority, rural and medically under-resourced communities.
- Over 100 health care organizations used AMA solutions to help their physicians and care teams improve cardiovascular disease in patients. Through this collaboration, more than 4.1 million patients with hypertension were reached and over 2.3 million patients with hypertension were impacted to achieve improved blood pressure control; 39 percent of which, where data was available, were from historically underserved communities.
- In 2025, the AMA launched the new two-year AMA Transforming Lifelong Learning Through Precision Education portfolio to accelerate seamless lifelong learning and advance educational

equity. As part of the portfolio, the AMA will award a total of $12 million in education grant funding to a total of 11 selected grant teams, each receiving $1.1 million over four years. Grantees represent more than 80 institutions, including medical schools, residency programs, health systems, and specialty societies across the country. The selected grant teams will join the ChangeMedEd Consortium, which focuses on advancing precision medical education.

- The AMA published playbooks and other educational resources for physicians, practices and health systems, such as one of the AMA STEPS Forward® toolkits https://edhub.ama-assn.org/steps-forward/module/2830076 focused on quality improvement goals for practices. This STEPS Forward for Smaller Practices toolkit offers guidance on how a practice can better understand its patient population and community by examining population data, as well as intersectionality of identities.
- In 2025, the AMA hosted its sixth episode of the National Health Equity Grand Rounds webinar series, *Creating Conditions Vital to Health: Health Care's Role in Economic Progress,* at Rush Medical Center's Rubschlager Building in Chicago. Health care leaders discussed how health systems can invest in their communities to address vital conditions and improve health outcomes for all. This event engaged 19 health care organizations, and a total of 362 physicians joined the conversation.
- Three new collaborators joined the AMA's Ed Hub™ in 2025, including the Institute for Exceptional Care, Cleveland Clinic Center for Continuing Education and University of Washington. These organizations will be contributing to equity-focused content on the AMA Ed Hub™ site and expand AMA high-impact learning.
- The AMA's 2025 media sponsorships focused on reaching diverse audiences, supporting events with the National Association of Hispanic Journalists and the Asian American Journalists Association.
- In 2025, the AMA concluded the first cohort of the Equitable Professional Societies Learning Network aimed to help 17 state and specialty societies gain the knowledge, skills, resources and tools to operationalize structural changes for optimal health outcomes.
- The third cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute, culminated at the 2025 Interim meeting of the House of Delegates, where 10 physician leaders were celebrated and presented their optimal health outcomes project concepts. The fourth cohort of the Medical Justice in Advocacy Fellowship will begin in 2026.
- AMA staff continued to be present throughout 2025 at underrepresented physician convenings to grow and foster relationships, as well as learn about health care priorities of these groups. Staff participated in various conferences to support building alliances, learning about the context necessary for restorative practice and incorporating context into the AMA's own work. These conferences included: National Hispanic Medical Association 28th Annual Conference, National Medical Association 123rd Annual Convention and Scientific Assembly and National Colloquium on African American Health, Association of American Indian Physicians 53rd Annual Meeting and Health Conference, National Council of Asian Pacific Islander Physician's He Huliau i ka Pono Conference, GLMA's 43rd Annual Conference on LGBTQ+ Health, among others. Staff gained insights into incorporating inclusive practices into the AMA's work.
- The AMA's Truth, Healing, and Reconciliation Taskforce (TRHT) focused on organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation and healing in medicine and medical education. In 2025, the TRHT taskforce concluded after two years having engaged six professional societies, three health care organizations and two institutions. There was a total of six education sessions focused on restorative justice in medicine with a total of 285 physicians in attendance across all sessions.
- As part of The AMA Foundation's Optimal Health Outcomes Accelerator fund, the AMA completed work toward the Equity and Justice in Medical Education (EJME) collaborative grant

focused on promoting equitable practices and diversity in the admissions process by forging more productive relationships between the AMA and underrepresented physician and student organizations. A total of six convenings were held to foster collaboration between participants with the hope of developing common approaches that will leverage collective influence. The participating organizations included: the National Medical Association, National Hispanic Medical Association, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical Student Association, Association of Native American Medical Students and Student National Medical Association.

Policy Development

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

- Optimal health outcomes-related policy priorities can be seen throughout the AMA's engagement with Congress, the Administration, state legislatures, and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and state medical organizations and countless additional opportunities that engaged organized medicine and policymakers. In 2025, the AMA continued to actively voice support for:
    - International medical graduates;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program coverage extension;
    - Maternal and child health programs;
    - Protecting reproductive health;
    - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
    - Protections for physicians who seek care for wellness and burnout;
    - Student loan accessibility and adequacy;
    - Increased funding for graduate medical education;
    - Telehealth flexibilities in Medicare;
    - Reducing the prior authorization burden on patients; and
    - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.
- The AMA continues to amplify voices of historically underrepresented individuals through its litigation efforts. Litigation efforts in 2025 ranged across topics including preventive care costs under the Affordable Care Act (ACA), smoking cessation efforts and regulations, access to health care and protecting the patient-physician relationship, among others. The AMA's work in the courts helped achieve favorable outcomes in several litigation efforts in addition to supporting state medical societies' efforts.
- The AMA's Office of International Relations (OIR) reviewed the World Medical Association's (WMA) policies through an optimal health outcomes lens. The AMA contributed to the revision of the WMA's Statement on Trans People, supported the reaffirmation of the WMA's resolution on human rights violation against Uighur People in China, and contributed to the WMA's Statement on Ageing, advocating for aging physicians' contributions.
- The AMA continued to update internal practices in line with inclusion efforts. For example, the AMA continues to work toward identifying and replacing offensive terminology across the enterprise through institutional level policy. The AMA conducted a comprehensive search for outdated terms within its IT systems and has embarked on instituting these updates to replace harmful language.

Research

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

- The AMA continues to be a partner on the National Quality Forum's Advancing Collection of Standardized Symptoms Data. The initiative aims to engage physicians in data standard development by standardized patient symptom data across care settings to improve diagnosis, measurement and quality of care. The initiative focuses on improving patient-focused outcomes.
- In 2025, the AMA Guides to the Evaluation of Permanent Impairment Sixth Edition updated its pulmonary function chapter in accordance with existing AMA policies on race as a social construct and national standards of care. Specifically, a race-neutral approach to pulmonary function test interpretation algorithms was implemented by reporting and interpreting results using average reference equations rather than using race-based calculations. An additional update was the acknowledgement that pulse oximetry can have measurement errors in people with dark skin pigmentation and a call to mitigate these errors whenever possible.
- AMA staff co-authored more than 30 peer reviewed publications, including papers in Journal of the National Medical Association, JAMA Network Open, New England Journal of Medine and Journal of General Internal Medicine, as well as contributed to the American College of Cardiology and American Heart Association Joint Committee on Clinical Practice Guidelines.
- The AMA Journal of Ethics published optimal health outcomes-related issues such as Surgical Care of Incarcerated Patients (April 2025), Private Equity in Health Care (May 2025), Rural US Emergency Medical Services (July 2025) and Screening Children for Structural Drivers of Health (September 2025).
- The JAMA Network continued curating and sharing digital content relating to health outcomes across its publications, distributed to more than 13,000 subscribers. As an example, the JAMA Network launched the JAMA+ Women's Health, a new digital resource aimed to elevate the visibility and accessibility of trusted, peer-reviewed content that advances health care for women across the globe. Recognizing that women's health is comprehensive, JAMA+ Women's Health showcases rigorous studies that include or focus exclusively on women from across JAMA and the 12 JAMA Network journals. Furthermore, the AMA contributed to the JAMA publication Toward a Safer World by 2040, capturing proceedings from the JAMA Summit on Firearm Violence, charting an innovative roadmap toward reduction in firearm harms by 2040.
- The JAMA Network held its quarterly Equity, Diversity, and Inclusion (EDI) editor meetings to support EDI related concerns and share best practices across the network. Additionally, JAMA Network published a Research Letter titled *Equity, Diversity, and Inclusion Concerns from JAMA Network Peer Reviewers*, which discussed results related to EDI framing, methods, terminology and language concerns gathered across all JAMA Network journals' peer reviewer forms. Results were also presented at the 2025 Peer Review Congress.
- Diverse representation among AMA publications remained a goal in 2025. The AMA updated 30 illustrations for the 2026 CPT Professional book to reflect all populations. Input was gathered from internal and external reviewers. This progress is contributing to the AMA's five-year plan to update over 100 CPT Professional book illustrations to depict authentic and diverse individuals.
- The AMA integrated equitable practices across its market and user experience research by aligning research questions with AMA's data privacy practices, ensuring populations of focus were appropriately represented and considering vendors based on their expertise and experience working with participants involved in the research. Additionally, the AMA conducted a market assessment to analyze how other organizations have diversified medical illustrations in their materials.

CONCLUSION

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

REPORT 10 OF THE BOARD OF TRUSTEES (A-26)
AMA Efforts on Medicare Payment Reform

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System," and amended Policy D-390.922, "Physician Payment Reform and Equity," declaring Medicare physician payment reform an urgent advocacy priority and directing the Board of Trustees to report regularly on progress toward achieving a predictable, sustainable, and fair physician payment system. In addition, the House adopted Policy D-400.981 at the 2025 Annual Meeting, calling for greater transparency regarding the AMA's Medicare payment reform strategy and requiring regular updates to the House on advocacy efforts, barriers to reform, and opportunities to strengthen the strategy. This report responds to those directives and provides an update on the AMA's ongoing efforts to advance Medicare physician payment reform.

The current Medicare physician payment system continues to place significant financial strain on physician practices. The calendar year 2025 Medicare Physician Fee Schedule (MPFS) included a 2.83 percent reduction in physician payment rates, continuing a pattern of recurring cuts that has persisted for several years. Although Congress provided a temporary 2.5 percent update for 2026, statutory updates under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) remain well below the rate of growth in physician practice costs placing increasing pressure on physician practices and raising concerns about patient access to care.

The AMA has advanced a comprehensive advocacy strategy focused on several key reforms: establishing permanent annual payment updates tied to the Medicare Economic Index, modernizing outdated budget neutrality requirements that trigger destabilizing payment reductions, improving the Merit-based Incentive Payment System to reduce administrative burden, and expanding opportunities for physician participation in advanced alternative payment models. The AMA has pursued these priorities through sustained legislative advocacy, engagement with federal policymakers and advisory bodies, collaboration with state medical associations and national medical specialty societies across the Federation, and extensive grassroots, media, and public outreach efforts.

In parallel, the AMA has begun implementing a strategic review of its Medicare payment reform advocacy in response to House policy calling for greater transparency. This review will assess barriers to reform, evaluate opportunities to strengthen current advocacy efforts, and identify recommendations to accelerate progress toward achieving a rational Medicare physician payment system.

While recent congressional actions have provided limited short-term relief, meaningful structural reform remains necessary to stabilize physician payment and protect patient access to care. The AMA will continue working with Congress, the Administration, and Federation partners to advance policies that ensure payment adequacy, reduce administrative burden, and support physician participation in innovative care delivery models.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 10-A-26

Subject: AMA Efforts on Medicare Payment Reform

Presented by: David H. Aizuss, MD, Chair

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

1. Provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.

2. Share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.

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

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

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

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

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;

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- Simplified and clinically relevant policies under the Merit-based Incentive Payment System; and
- Greater opportunities for physician practices that want to transition to advanced alternative payment models (APMs).

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

Legislative Advocacy

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

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

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

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

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

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

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

When practices are forced to close, consolidate, or limit the number of Medicare patients they can treat, access to care is threatened for millions of seniors and patients with disabilities.

Expanding the physician workforce alone will not solve these access challenges if newly trained physicians enter a Medicare system that remains financially unsustainable.

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

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

The current Medicare physician payment system is characterized by stagnant base payments, the absence of permanent annual inflationary updates, and excessive administrative burdens. Unlike hospitals and other Medicare providers, physicians do not receive automatic inflationary adjustments tied to rising practice costs. This pattern of recurring reductions and structural instability is undermining the financial viability of physician practices nationwide.

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

Medicare Reform: Automatic Annual Inflation-Based Updates

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

Medicare Payment Reform: Budget Neutrality

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

Medicare Payment Reform: Revising the MIPS Program

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

119th Congress AMA Advocacy Highlights

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

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

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

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

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

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

National Advocacy Conference – February 2026

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

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

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

Grassroots, Media, and Outreach

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

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

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

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

Senate Legislation and H.R. 1

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

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

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

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

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

Federation Engagement

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

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

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

Advocacy with MedPAC and Looking Forward

The AMA continues to engage with MedPAC as it evaluates the adequacy of Medicare physician payment and develops recommendations to Congress. During its December 2025 meeting, MedPAC discussed a potential recommendation to update Medicare physician payment rates in 2027 by current law plus 0.5 percent, which would result in an update of approximately 1.25 percent for clinicians participating in advanced alternative payment models and 0.75 percent for

other physicians. However, the cost of providing care is expected to increase by approximately 2.1 percent, meaning that such a recommendation would allow the gap between physician payment and practice cost inflation to continue widening.

In recent comments submitted following the meeting, the AMA urged MedPAC to recommend that Congress update physician payment in 2027 by the full increase in the MEI. The AMA emphasized that aligning physician payment updates with practice cost inflation is necessary to improve payment stability, preserve private physician practices, and maintain patient access to care.

The AMA also highlighted MedPAC data showing emerging access challenges for Medicare beneficiaries. In 2025, 29 percent of beneficiaries reported waiting six or more weeks to see a new primary care physician and 31 percent reported similar waits to see a new specialist. At the same time, growth in spending under the Medicare Physician Fee Schedule has remained modest compared to other components of Medicare Part B, with physician fee schedule spending per beneficiary increasing far more slowly than overall Part B spending in recent years.

The AMA will continue working with MedPAC to ensure that its recommendations to Congress reflect the growing gap between physician payment and practice cost inflation and the potential implications for patient access to care.

Call to Action

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

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

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

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

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

STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

In response to Policy D-400.981, the AMA is conducting a comprehensive review of its Medicare payment reform advocacy strategy. This effort includes evaluating opportunities to engage external advocacy consultants and refining internal processes to identify barriers, assess strategic gaps, and develop targeted recommendations to strengthen ongoing reform efforts. While this work is

ongoing at the time this report was prepared, the AMA remains committed to advancing this review and will provide an update at the 2026 Interim Meeting.

CONCLUSION

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

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

REPORT 11 OF THE BOARD OF TRUSTEES (A-26)
AMA Public Health Strategy Update

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," adopted by House of Delegates at I-21 directed our American Medical Association (AMA) to develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress. Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has called for the AMA to report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence. This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

In the last year, there have been many changes in the federal administration and changes to policies and funding levels, as well as scientific advisory committees that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, which will result in increasing health inequities. The intent of this report is to share the work that the AMA has done to advance our current public health priorities, which are as follows:

1. Promote evidence-based clinical and community preventive services.
2. Respond to public health crises impacting physicians, patients, and the public. This includes:
    - addressing the threat of climate change,
    - preventing firearm injuries and deaths,
    - preparing for emerging and remerging infectious disease threats, and
    - ending the nation's drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
4. Combat the spread of misinformation and disinformation.

CONCLUSION

The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture the work accomplished from March of 2025 – March of 2026 related to the AMA's current public health priorities. In the current environment, AMA continues efforts to maintain AMA's standing as a trusted source of information for physicians and the public and to help protect the nation's health.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-A-26

Subject: AMA Public Health Strategy Update

Presented by: David H. Aizuss, MD, Chair

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

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

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

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

DISCUSSION

What is Public Health?

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

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.[4] Progress towards the AMA's health

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equity strategy is reported in the Board of Trustees (BOT) annual health equity report. (See BOT Report 9-A-26, "American Medical Association Health Equity Annual Report.")

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

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

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

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

In early 2025, the structure of the USPSTF was being challenged in the courts. On June 27, 2025, the U.S. Supreme Court ruled in *Kennedy v. Braidwood Management, Inc.* that the structure of the USPSTF was constitutional. The Court upheld the Affordable Care Act's (ACA) requirement that private insurers cover USPSTF "A" and "B" rated preventive services without cost-sharing. The Supreme Court also confirmed the HHS Secretary's authority to remove and appoint members of the task force.

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

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

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

- On June 9, 2025, the AMA issued a statement on the removal of the 17 sitting members of ACIP and noting that it undermines trust in a process that has saved countless lives.
- On June 12, 2025, the AMA issued a statement on new members of the ACIP selected without transparency and proper vetting.
- On June 13, 2025, the AMA sent a letter to Senate leadership regarding the actions by HHS to terminate the appointments of the 17 voting members of the ACIP and urged an inquiry into the circumstances surrounding the decision to remove and replace all sitting members.
- On June 18, 2025, the AMA sent a letter to HHS expressing significant concern regarding the recent action to terminate the entirety of the membership of the ACIP.

- On August 1, 2025, ACIP medical society liaison organizations issued a joint statement regarding their removal from ACIP vaccine workgroups.
- On September 19, 2025, the AMA issued a statement on ACIP's new MMRV vaccine recommendations.
- Oct. 15, 2025, the AMA joined an amicus brief in the case of *AAP vs. Kennedy* calling for government recommendations regarding the COVID-19 vaccine to reflect the full body of medical evidence and to follow the statutorily process for the provision of vaccine guidance.
- On December 5, 2025, the AMA issued a statement on ACIP vote to weaken the birth-dose recommendation for the hepatitis B vaccine.
- On December 15, 2025, the AMA issued a statement on the CDC hepatitis B birth dose decision.
- On January 5, 2026: the AMA issued a statement on changes to the childhood vaccine schedule.
- On January 23, 2026, the AMA issued a statement on the ACIP chair's comments on polio, routine vaccinations.

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

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

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

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

- To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances

with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

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

C. Counseling Patients on Nutrition to Promote a Healthy Diet

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

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

- On January 7, 2026, the AMA released a press statement applauding the Administration's new Dietary Guidelines for spotlighting the highly processed foods, sugar-sweetened beverages, and excess sodium that fuel heart disease, diabetes, obesity, and other chronic illnesses.
- On March 5, 2026, the AMA joined the Department of Health and Human Services (HHS) and the U.S. Department of Education at a convening of leaders from 53 of the nation's top medical schools across 31 states to announce commitments to meaningful nutrition training beginning in the next academic year.
- On March 24, 2026, the AMA announced the launch of a nutrition education initiative to equip physicians and medical students with practical, evidence-based knowledge and tools to help patients live healthier lives. The program will feature webinars, roundtables, and additional resources on the AMA Ed Hub™. This work is part of an ongoing effort by the AMA to advance nutrition education across the medical education continuum and elevate nutrition as a core component of patient care.

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

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

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

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

The AMA continues to work on the "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings" project. The scope of this project has included developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit contains two different sets of

strategies – one targeted to community health centers (CHCs) and a second to emergency departments (EDs). In the past year the AMA has been working to scale the adoption and implementation of the quality improvement strategies in the toolkit across CHCs and EDs.

- The toolkit was launched to the public in March 0f 2024.[7] Since its launch, the toolkit has had over 27,000 page views, over 18,000 views of the launch series webinars and over 1,400 downloads of the PDF toolkit.
- In 2025, 15 CHCs and EDs from across the country were selected to participate in a 6-month Community of Practice (CoP). The AMA hosted five 30-minute tele-mentoring sessions to advance quality improvement strategies within the toolkit. The AMA also hosted six 60-minute office hour sessions where CoP members could discuss their challenges in implementing routine screening.
- The AMA also identified three national organizations to promote the routine screening toolkit to their members during 2025 (Alliance Chicago, Society of Academic Emergency Medicine, and the National Coalition of STD Directors).
- In 2026, the AMA is expanding to host a CoP that is open to any CHC or ED that wants to start or expand routine screening for these infectious diseases. A work group of four experts is meeting monthly to shape the hour-long office hours. Once again, the office hours will serve as a safe place for clinicians to share their challenges and get assistance with everything from patient education to care team workflow to EMR optimization.
- The toolkit will be expanded in 2026 with webinars focusing on improving routine screening in specific populations with a focus on patients with substance use disorders, patients who are pregnant, and rural populations.
- In addition to the work on the routine screening toolkit, the AMA has also received funding from the CDC to explore barriers in accessing preventive medications including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and doxycycline post-exposure prophylaxis (doxy PEP) for STIs to inform the development of tools and resources to help overcome these barriers.
- The AMA worked with a vendor to conduct two discussion groups looking at barriers to PrEP and doxy PEP prescribing. Five SMEs and three non-SMEs gave their thoughts on current challenges and potential solutions. The AMA will develop a work group to use these findings to develop targeted education and resources to improve access to these interventions.

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

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

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

GetMyFluShot.org for more information, including where to get a flu vaccine in their area. Some highlights from the 2025-26 flu campaign are as follows:

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

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

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

A. Address the public health crisis of climate change.

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

- The AMA continues to make climate change and sustainability education available via the Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and Equity, Stanford Medicine, AMA Journal of Ethics, the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA).
- In 2025, the AMA organized a three-part webinar series on climate and health, which is available on AMA's Ed Hub. The three webinars covered the hidden health impacts of climate change, planning for climate resilience in the health care sector, and decarbonizing health care.
- The AMA is in the process of developing a CME module for physicians and trainees on climate change and health. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it.
- In December 2024, AMA developed and distributed a survey to physicians to assess perceptions on climate change and health, including the level of importance and relevance of climate change to physicians, understanding day-to-day effects of climate change that physicians may be experiencing or anticipating experiencing in the future, and exploring what the AMA's role should be in supporting physicians on climate change. Findings from this survey were presented at the APHA 2025 Annual Conference (November 2025) and an

abstract on the survey findings has also been accepted at National Association of City and County Officials annual conference (April 2026). A publication intended for a peer-review journal is drafted with intended publication in 2026.

- AMA staff moderated a panel discussion entitled "Clinician and Health System Responses to Extreme Weather," at the inaugural Illinois Extreme Weather and Health summit, held on November 12-13, 2025, in Chicago, IL.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH), which brings together associations representing over 600,000 clinical practitioners.[12] The AMA sits on the executive committee of this group and through the MSCCH the AMA represents the U.S. to the Global Climate and Health Alliance. Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March 2026 in Arlington, VA.
- The AMA is a member and sponsor of the National Academy of Medicine (NAM) Action Collaborative on Achieving a Climate Resilient and Sustainable Health Sector (Climate Collaborative) and is represented on the Steering Committee and served as a co-lead of the Health Care Delivery Workgroup (Phase 1 and 2). The Health Care Delivery Workgroup focused on three deliverables in Phase 2, which included:
    - Hosting the "Building Momentum to Act on Health Care Decarbonization" Webinar Series**.** All recordings, slides, and resources have been published. We also developed a 1-page overview summarizing key findings and takeaways from the series.
    - Developing a list of Key Actions for Health Professionals to Advance Sustainable Health Care (Health Professionals Shortlist), which has been published.
    - Developing a Climate Journey Map: Clinical Pathway, which was published. We are continuing to review new resource submission monthly with Journey Map updates published on a quarterly basis.
    - The Committee's Phase 3 work will focus on redefining quality through climate action and building the evidence.
- Additionally, the AMA participates in the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.[13] The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. The AMA also became a member of the newly formed Alliance for Heat Resilience and Health, which includes over a dozen national organizations working in collaboration to advance protective standards, proactive emergency plans, and local and state-based engagement around extreme heat.
- In terms of advocacy efforts, the AMA joined with partners or submitted comments separately on the following:
    - On February 4, 2026, the AMA joined 19 medical and health organizations in a letter opposing the National Highway Traffic Safety Administration's proposed weakening of fuel efficiency standards for vehicles and light trucks.
    - On September 22, 2025, the AMA joined 120+ medical and health organizations in a letter opposing the EPA's proposed repeal of the 2009 Greenhouse Gas Endangerment Finding and Greenhouse Gas Vehicle Standards.
        - The AMA provided testimony to the EPA affirming the importance of the Greenhouse Gas Endangerment finding and noting the public health impacts of climate change.
    - On August 7, 2025, sent a letter opposing the EPA's proposed rule to repeal Greenhouse Gas Emissions Standards for Fossil Fuel-Fired Electric Generating Units.

B. Prevent firearm injuries and deaths.

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

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

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

- On Thursday, March 6, 2025, AMA participated in a Washington Post Live conversation about how gun violence has impacted communities around the country, initiatives to find common ground, and efforts to bolster public safety and health.
- On October 23, 2025, the Ad Council in partnership with the American Medical Association, through the work of the task force and a coalition of health care and business leaders, launched new firearm injury prevention creative and an expanded digital resource hub for health care professionals at AgreeToAgree.org/Healthcare. The resource hub provides links to educational materials to support physicians having effective conversations about firearm injury prevention with patients, parents, other health care professionals and community members.
- In the first year of the Agree to Agree campaign, it has:
    - Received 35.4 million in total donated media resulting in 2.4 billion impressions.
    - Reached 69.5 percent of the audience in first 4 months of campaign launch, according to a Nielsen One study.

- All three impact goals were met. Respondents aware of the campaign advertising are significantly more likely than those not aware to: (1) know firearm injuries are the leading cause of death for youth, (2) believe they have a role to play, and (3) report having had a conversation about preventing youth firearm injury and deaths.
- Agree to Agree was number one for share of voice for the Gun Violence Safety category for 2025.

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

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond traditional borders. Measles, which was once eliminated in the U.S., continues to surge with 2,284 confirmed cases in 2025. The U.S. is on pace to surpass that number in 2026, with 1,362 cases already reported as of March 12, 2026. The AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.

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

D. End the nation's drug overdose epidemic.

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

- The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment to meet regulatory requirements. Courses are developed by AMA as well as by other partners.

  - In 2025, the AMA developed and disseminated physician education, "Safer Prescribing of Opioids for Pain Management: Bridging Guidelines and Practice Through Interactive Learning" to support physician's improving their opioid prescribing. This education received two Brandon Hall Group Educational Awards for Leaders in Education Technology – Best E-learning, Blended, Flipped Classroom Solution and Learning and Development Technology Award – Best Advance in Education Delivered Through Technology.
  - In 2025, the AMA developed additional episodes of the physician education podcast series on "The Opioid Overdose Epidemic." Podcast episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. In 2025, podcast engagement included 26,757 downloads, with a high interest in the following topics: "Opioid Prescribing and Appropriate Pain Management,"" Opioid Overdose Prevention," and "Opioid Use Disorder Treatment."
  - In the past year, the AMA supported the content for the physician education series module "Practical Guidance for Pain Management." This content was made available to help physicians meet the DEA's MATE Act requirements, effective as of June 27, 2023.
- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.[21] This group meets on a quarterly basis throughout the year to engage with stakeholders and experts with emerging barriers, challenges and development of solutions
- The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.[20]
- The AMA is a sponsor of the National Academy of Medicine, Action Collaborative on Combatting Substance and Opioid Crises. The Action Collaborative is committed to proactively driving structural change by developing, curating, and implementing multi-sector solutions designed to reduce substance misuse and improve outcomes for individuals, families, and communities affected by addiction.
- The AMA was awarded funding from the CDC in 2024 and continued work to develop and implement a clinician toolkit focused on the recommendations and guiding principles of the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically tailored to community health centers (CHCs). During the two-year project period, the AMA will partner with the National Association of Community Health Centers to develop an actionable toolkit resource for clinicians and will implement the toolkit resource in CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational experience for clinicians working in CHCs that is unique and sensitive to the needs of CHCs while also preparing them to serve as content experts and agents of change for their local healthcare communities regarding pain care.
- The AMA continues to be a data resource for stakeholders, policymakers, clinicians, and researchers with its "End The Epidemic" website and data dashboard. This website maintains up to date resources for stakeholders to utilize and an interactive data dashboard to highlight regional differences and trends of the drug overdose epidemic.
- The AMA released its 2025 Substance Use and Treatment: Progress, Policy and Future Directions Report showing increases in polysubstance use, naloxone access for life-saving

intervention, and policy promoting evidence-based care but underscoring ongoing challenges as the nation's drug overdose epidemic continues.

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

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

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

In addition, the AMA took the following actions:

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

4. Combat the spread of misinformation and disinformation.

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

- The Coalition for Trust in Health and Science's vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming.

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

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

CONCLUSION

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

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 16-A-26

Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: David H. Aizuss, MD, Chair

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

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

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

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

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

DATA SOURCES

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

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

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates credentialed for the November 2025 Interim Meeting is less than the 733 allocated and the number of alternate delegates credentialed is nearly always less than the full allocation. As such, the total number of

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delegates and alternate delegates credentialed for the 2025 Interim Meeting is 1186 rather than the 1466 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 10 percent of AMA members and approximately 22 percent of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

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

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

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

	AMA Members	All Physicians and Medical Students	HOD Delegates & Alternates (credentialed)
Total	322,123	1,612,618	1,186
Mean age (years)	46.6	52.7	53.9
Age distribution			
Under age 40	51.12%	31.52%	20.07%
40-49 years	13.31%	16.92%	19.14%
50-59 years	10.82%	15.10%	19.90%
60-69 years	8.62%	14.51%	22.93%
70 or more	16.13%	21.95%	17.96%
Gender			
Male	57.23%	60.74%	57.59%
Female	41.98%	38.57%	42.24%
Unknown	0.79%	0.69%	0.17%
Race/ethnicity			
American Indian or Alaskan Native	0.15%	0.17%	0.59%
Asian	17.50%	16.04%	16.10%
Black or African American	4.96%	4.36%	5.99%
Hispanic, Latino, or Spanish Origin	4.22%	4.31%	3.29%
Middle Eastern or North African	0.08	0.02%	0.00%
Multi-Race/Ethnicity	6,87%	5.19%	3.37%
Native Hawaiian or Other Pacific Islander	0.04%	0.03%	0.00%
White	45.08%	47.11%	58.77%
Other	1.64%	1.64%	1.60%
Unknown	19.47%	21.14%	10.29%
Education			
US or Canada	80.47%	77.49%	90.47%
IMG	19.53%	22.51%	9.53%

	AMA Members	All Physicians and Medical Students	HOD Delegates & Alternates (credentialed)
Life Stage			
Student2	17.18%	9.08%	5.73%
Resident2	26.61%	11.09%	8.09%
Young (under 40 or first 8 years in practice)	12.01%	15.53%	8.52%
Established (40-64)	24.01%	35.05%	48.82%
Senior (65+)	20.20%	29.25%	28.84%
Present Employment			
Self-employed solo practice	4.97%	6.40%	9.19%
Two physician practice	1.22%	1.67%	1.60%
Group practice	28.61%	39.91%	41.57%
HMO	0.25%	0.13%	0.76%
Medical school	0.74%	1.18%	3.12%
Non-government hospital	3.58%	4.55%	7.67%
State or local government hospital	3.28%	5.04%	9.95%
US government	0.69%	1.30%	2.28%
Locum Tenens	0.12%	0.16%	0.34%
Retired/Inactive	9.77%	13.16%	7.93%
Resident/Intern/Fellow	26.61%	11.09%	8.09%
Student	17.18%	9.08%	5.73%
Other/Unknown	2.97%	6.32%	1.77%
Specialty			
Family Medicine	9.21%	11.12%	11.64%
Internal Medicine	22.18%	22.67%	20.49%
Surgery	12.36%	12.47%	18.72%
Pediatrics	5.93%	8.45%	4.22%
OB/GYN	4.88%	4.32%	6.91%
Radiology	3.32%	4.14%	4.89%
Psychiatry	4.28%	5.04%	4.22%
Anesthesiology	3.62%	4.27%	2.95%
Pathology	1.61%	2.02%	2.28%
Other specialty	15.41%	16.42%	17.96%
Students	17.18%	9.08%	5.73%

Appendix

Specialty classification using physician's self-designated specialties.

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 18-A-26

Subject: Report on the Preservation of Independent Medical Practice

Presented by: David H. Aizuss, MD, Chair

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

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

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

DISCUSSION

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

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

Providing a voice for independent physicians in AMA policy development

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

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

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

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

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

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

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

Outreach and engagement with independent physicians

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

Each year, the Section hosts two primary engagement events:

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

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

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

Advocacy in support of independent practice

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

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

sounding the alarms on health insurer practices that bypass the NSA and threaten the sustainability of independent practices. AMA has also supported the No Surprises Act Enforcement Act in the House and Senate.

- The AMA has continued federal and state legislative advocacy on insurer administrative practices, and accountability measures including releasing a state model bill on insurer downcoding practices, physician-led team-based care, physician wellness, advancing technology including augmented intelligence, access to care, and medical liability consistent with adopted House of Delegates policy. In addition, AMA has participated in legal advocacy, including amicus curiae activity, in matters affecting physician reimbursement and practice viability.

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

Promoting resources for the advancement of independent practice

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

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

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

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

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

CONCLUSION

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

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 26-A-26

Subject: AMA Ethics Fellowships

Presented by: David H. Aizuss, MD, Chair

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-300.971, "Upholding Professional Integrity and Ethical Leadership," which states the following:

1. Our American Medical Association is committed to sustaining accessible, physician-led education and discourse on the ethical challenges in medicine.

2. Our AMA will develop and publicize opportunities for medical ethics engagement and learning across the association.

3. Our AMA will continue to advance and fund opportunities for editorial fellowships in ethics for trainees and early-career physicians commensurate to the AMA Journal of Ethics Editorial Fellowship.

4. Our AMA will report back on its progress and advancement for medical ethics engagement and editorial fellowships for trainees and early-career physicians at Annual 2026.

This report is submitted as information to the House of Delegates about a new ethics opportunity at the AMA.

NEW ETHICS FELLOWSHIP

Building on the *AMA Journal of Ethics*' record of engagement with the next generation of physicians, a new ethics fellowship, crafted to retain key elements that were valued by past journal editorial fellows, was recently launched. Key aspects of the new fellowship program are as follows:

- Every April, a "Call for Ethics Fellows," seeking applications from medical students, resident physicians, and fellows in U.S.-based accredited MD or DO programs, will be posted and promoted though AMA membership and communication channels.

- Fellowship applications will propose a timely and important medical ethics topic and how it can be explored through a multimedia approach such as video or podcast.

- Fellows will also secure a faculty mentor who will work along with AMA Ethics staff to help them conceptualize the topic, refine questions to be addressed, and identify experts to be featured. It is worth noting that this opportunity to collaborate with subject matter experts in their home institution (and the AMA) was routinely highlighted in Dean's letters

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of previous journal editorial fellows and became an insightful point of conversation during medical students' residency interviews.

- Up to six Fellows will be selected in response to the annual Call with each Fellow receiving a $2,500 honorarium. The number of Fellows per year may increase over time to meet growing interest and available resources.

- All selected Fellows will meet in Chicago for a working conference with reasonable travel expenses covered by the AMA. Led and facilitated by AMA staff this Chicago meeting will provide a valuable opportunity for the Fellows to learn from and work with their peers to further refine and develop their multimedia content outline.

- Multimedia production will be handled within the AMA. The finalized multimedia content with CME credit will be published on the AMA EdHub platform.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 30-A-26

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

Presented by: David H. Aizuss, MD, Chair

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates. This informational report responds to the first directive of the policy:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).

In 2025, AMA received requests from 21 societies to participate in the HOD EAP program. Three societies did not meet the criteria outlined in the policy adopted by the House. The EAP awarded grants to the remaining 18 federation societies.

Each qualifying society was required to submit a grant funding request form for each of the 2025 Annual and Interim Meetings indicating the number of delegates and alternates, regional medical student delegates and sectional resident and fellow delegates to be funded for each organization. Fifty percent of the requested amount was paid prior to the meeting with the remainder paid out based on verified actual attendance following the meeting.

For example, if a qualifying association had requested grant funding for four delegates and four alternates, two regional medical student delegates and one sectional resident delegate, that society would be eligible for grant money for 11 attendees or $16,500. The initial payment would have been calculated and paid at 50 percent of the requested amount or $8,250. Assuming only nine of those included in the initial request attended the meeting, the total grant would be recalculated at $1,500 times nine attendees or $13,500 and the final payment would be the difference between the recalculated grant amount and the first installment payment or $5,250. This was to ensure that grant funding is used solely for actual delegates and alternate delegates attending the meeting.

Based on grant funding requests, a total of $420,000 was made available for the 2025 Annual Meeting and 50 percent or $210,000 was paid to societies in advance of the meeting. After verification of actual attendance, a total number of delegates and alternate delegates attending the meeting from the 18 approved societies was 246, including 14 sectional residents and 16 regional students and the grant amounts paid for the Annual Meeting totaled $368,400.

For the November 2025 Interim Meeting, a total of $331,200 was made available and 50 percent or $165,600 was paid to societies in advance of the Interim Meeting. After the verification of actual attendance, the total number of delegates and alternate delegates attending the meeting was 243, including 13 sectional resident/fellows and 18 regional students and the total grant amounts paid for the Interim Meeting was $285,100. It should be noted that total funding for an organization was

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capped at $100,000 for the year and final payments were adjusted so that no society exceeded this cap.

In 2026, AMA received 24 requests to participate in the EAP program. Three organizations did not meet the criteria for the program. The EAP program will award grants to the remaining 21 federation societies which may potentially fund up to $872,200 for 315 delegates and alternates, 22 regional medical students and 15 sectional resident and fellow delegates and alternates for both the Annual and Interim Meetings. Funding requests are currently in process for the 2026 Annual Meeting.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 31-A-26

Subject: Establishing an Advisory Committee on AI/AN Affairs

Presented by: David H. Aizuss, MD, Chair

At the 2025 AMA Annual Meeting, the House of Delegates (HOD) adopted Policy D-615.976, "Advisory Committee on Tribal Affairs," which directs the AMA to:

> Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
>
> Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness."

At the 2025 AMA Interim Meeting, the Board of Trustees presented an informational report, BOT Report 17, indicating that that Board was taking the necessary steps to form an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs and would report back at the 2026 Annual Meeting. This follow-up report is informational.

At its November 2025 meeting, the Board approved a charter for a new Advisory Committee on AI/AN Affairs. Under this charter, the Advisory Committee will advise the Board and AMA management on policy and advocacy matters pertaining to AI/AN medical students, physicians, and patients, and otherwise contribute to AMA initiatives related to this population.

The charter creates a seven-member Advisory Committee composed of:

- One medical student member,
- One resident or fellow member,
- One young physician member,
- Three physician members at-large (non-medical student/resident/fellow), and
- One physician representative of the Association of American Indian Physicians (non-medical student/resident/fellow).

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Advisory Committee members are appointed by the Board, prioritizing candidates who:

- Have close professional relationships with AI/AN communities; and/or
- Have direct experience working with AI/AN communities through Indian Health Service programs, tribally operated programs, Urban Indian Health Programs, or other programs serving AI/AN communities.

The Board appointed the following members to the inaugural Advisory Committee, which will convene for the first time in conjunction with the 2026 AMA Annual Meeting:

- Medical student member: Mateo Perez
- Resident/fellow member: William Swain, MD
- Young physician member: Hannah Catherine Wenger, MD
- Member at-large: Janice Heaton-Sheufelt, MD (Vice Chair)
- Member at-large: Donald Warne, MD
- Member at-large: Siobhan Wescott, MD (Chair)
- AAIP Representative: Thomas “Blair” Matheson, MD

REPORT OF THE BOARD OF TRUSTEES

BOT Report 32-A-26

Subject: Disability Advisory Group

Presented by: David H. Aizuss, MD, Chair

At the 2021 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD) BOT Report 19-I-21, "Advocacy for Physicians and Medical Students with Disabilities," was adopted.

The policy states: Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities.

This informational report provides the progress of the advisory group.

The Disability Advisory Group (DAG) has provided strategic guidance, subject matter expertise, and community outreach to ensure AMA policies and initiatives meaningfully address the needs of physicians, trainees, and patients with disabilities. The group currently includes 12 members with diverse representations, including disability type, career stage, and other identity factors—and incorporates input from external subject matter experts. The DAG has two active workgroups, one focused on education related to disability in medicine, and a second focused on strengthening accommodations in workplaces, educational institutions, and AMA meetings for physicians, trainees, and students with disabilities. With regular meetings and communication to the BOT through the two Board liaisons and other mechanisms, the DAG operates collaboratively to inform AMA efforts, always aligned with the organization's broader mission of supporting physicians and students, and optimizing health outcomes for all patients.

Current estimates suggest people with disabilities (PWD) are underrepresented in the physician workforce, with only 4.6 percent of medical students[1] and 3.1 percent of physicians[2] reporting a disability, compared to an estimated 26.7 percent of the adult U.S. population in 2022.[3] Federal law (the Americans with Disabilities Act[4]) requires public entities and employers to provide equal access and accommodations for PWD, ensuring non-discrimination and accessibility in services, programs, facilities, and employment opportunities. Data is not yet available regarding the prevalence of disability among AMA members; however, members of the DAG identified challenges to fully participating in AMA meetings due to unmet accessibility needs.

In addition to accessibility challenges, knowledge gaps regarding disability are shaped by the way disability is taught in medical education. Because training often emphasizes the medical model

(framing disability primarily as a health problem to be solved),[5] health care professionals' attitudes and practices may overlook other important factors. The biopsychosocial model of disability considers not only medical aspects, but also personal, social, environmental, and cultural contexts, offering a more complete understanding of disability.[6] This more expansive approach to disability is also supported by the World Health Organization.[7] Given this, the DAG identified the need to create additional educational resources for medical students and physicians to address ableism in medical training and improve quality of care for PWD.

DISCUSSION

2024-2025 ACCOMPLISHMENTS

In its first 18 months, the DAG collaborated with AMA staff, Board members, and aligned organizations (e.g., the Association of American Medical Colleges (AAMC) and the Docs With Disabilities Initiative (DWDI) to create educational content as well as operational and policy recommendations to improve disability inclusion in medicine and optimize health outcomes for people with disabilities (PWD).

Workplace Inclusion Workgroup

The Workplace Inclusion Workgroup reflected on gaps in accommodations for PWD experienced at past HOD meetings, and suggested changes to improve access for physicians and staff with diverse needs. Members of the working group collaborated closely with the staff to enact some of these changes in 2025.

Numerous strategies to improve access for physicians and others with disabilities were undertaken. For example, power strips were made accessible through the end of HOD meetings to ensure PWD can charge communication and mobility equipment as needed. The physical layouts of meeting venues were reviewed and adjusted to better accommodate wheelchairs; at the 2025 Annual and Interim meetings, for example, ramps were added to ensure access to all podiums. Specific areas for wheelchair users were also marked in reference committee meetings to ensure access, and microphone placements were reviewed and adjusted to allow wheelchair users and others with limited mobility to access them. Pressure sensors were added in front of microphones to communicate when someone approaches; this ensures Speakers are aware of all individuals waiting to speak, including PWD who may not be as easily seen as non-disabled physicians (e.g., when using a wheelchair). In addition to improving physical access at meetings, virtual spaces and digital content were reviewed and adjusted. For example, the font size and text color in presentations were updated to meet current web content accessibility guidelines, improving access for people with visual disabilities. Based on input from the DAG, the Meeting Services team supported the addition of live captioning and American Sign Language interpreters for 2025 meetings. There has been improvement in data collection and feedback regarding experiences of PWD as HOD attendees; however, this is currently collected in an ad hoc manner. Feedback mechanisms could be formalized for future meetings.

Education Workgroup

A dedicated education workgroup has advanced several initiatives to improve disability inclusion in medicine, both for physicians with disabilities and in providing better care for patients with disabilities. Informed by input from members of the DAG, expert interviews, and collaboration with key external organizations, staff is developing and platforming foundational educational

modules to address gaps in physician education around ableism in health care. These resources aim to help learners identify ableism, understand its impact, and foster more equitable health outcomes for PWD.

The DAG members contributed to designing multiple live educational events, including at the HOD Annual meeting in 2024 (recording platformed as enduring educational content here) and a panel discussion on disability inclusion in medical education at the 2025 Interim HOD meeting, both of which offer free CME. An interactive foundational module, "Disability Inclusion: Addressing Ableism in Medical Education and Health Care" was built in close collaboration with the DAG and published on EdHub in late 2025.[8]

2026 PRIORITIES

In 2026 and beyond, staff will continue the work initiated by the DAG. The DAG has identified opportunities to collaborate with other organizations (e.g., AAMC) to address challenges, e.g., the revision of technical standards that may inadvertently exclude students with disabilities from participating in medical education and training. Opportunities remain to review and suggest improvements to AMA policy and procedures as the Board considers how to address ableism in organizational policies and practices.

Workplace Inclusion Workgroup

While much has been accomplished with input from the DAG, work remains to ensure that AMA meeting spaces are inclusive of PWD. In 2026, the DAG Workplace Inclusion Workgroup will continue to collaborate with staff to improve accessibility and inclusion at AMA meetings, particularly the Annual meetings in Chicago. Key areas of exploration and focus will include: increasing time between sessions for PWD to move between rooms; creating a mechanism to signal that someone needs more time to reach a microphone before giving testimony; and involving DAG members or other PWD in 1) pre-meeting planning, 2) on-site accessibility assessments in hotels, and 3) venue selection for future sites. The workgroup will also continue to work to suggest feasible support for accommodating service animals and personal care assistants and propose funding mechanisms to support PWD attendees. They will continue to work with the Council on Long Range Planning and Development (CLRPD) to identify strategies through which the AMA can better understand the prevalence of disability and accommodation needs among HOD attendees and AMA members more broadly. Lastly, the workgroup aims to develop and share a model accessibility guide, with suggested operational improvements for varied workplace and educational settings.

Education Workgroup

Additional educational projects underway for 2026 publication include content to increase disability inclusion and improve care for PWD. Interactive modules to ensure a more inclusive environment for students and physicians with disabilities are being created in collaboration with the DWDI, focusing on addressing ableism in medical school admissions and residency selection. Furthermore, a video-based educational series is in development in collaboration with the University of Colorado's Anschutz School of Medicine. This series will equip clinicians with strategies to improve care for PWD and overcome common barriers in clinical settings.

CONCLUSION

The AMA Board of Trustees has determined that the DAG will continue for an additional two years and will continue the meeting cadence set forth in the original DAG Charter. The AMA Board of Trustees thanks the current DAG Members for all their work since the DAG was made effective on August 15, 2024. The AMA Board of Trustees will call for nominations for a new group of AMA members, whose AMA membership is active and in good standing, to serve on the DAG for the next two years (2026-2028). Current DAG members may reapply to serve during the 2026-2028 term. AMA staff will work with the new DAG membership to continue to improve the experience and inclusion of PWD by continuing to create educational and training content, developing policy recommendations, establishing inclusion practices in AMA-led spaces, and working in consultation with other aligned national organizations such as the AAMC, the Accreditation Council for Graduate Medical Education, DWDI and other relevant organizations to improve accommodations for, and inclusion of, PWD, in organized medicine.

Fiscal Note: To be determined

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REPORT 33 OF THE BOARD OF TRUSTEES (A-26)
Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," instructs the AMA to establish a task force to, "help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources." AMA Policy D-605.982 entitled, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," requires the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) to provide an annual report to the House of Delegates (HOD) at each Annual Meeting. Accordingly, this report highlights the Task Force's activities to date.

In 2024, the Task Force was formed by the AMA Board of Trustees (the Board) and began work to carry out the directives adopted by the HOD. There are 29 physician members serving on the Task Force: 11 representing national medical specialty societies, 10 representing AMA Councils, seven representing state medical associations, and one representing the Board. Staff from the respective medical associations are also invited to support their assigned physician members in Task Force activities.

To date, the Task Force has held six virtual meetings, four in-person meetings, and three informational sessions. The in-person meetings' agendas covered topics in legal issues, payment and reimbursement for gender-affirming care in adult patients, medical education and training, and public health and health outcomes. The discussions at these meetings generated numerous projects, including a web-based resource hub, research and resources on workforce impact, messaging and strategy research, the development of state law guides, support for the adoption of institution-level guidance, collaboration with prosecutors, and support for residents and medical students.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 33-A-26

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: David H. Aizuss, MD, Chair

This report provides an update on the activities of the American Medical Association (AMA) Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (the Task Force) in accordance with Policies G-605.009, D-5.998, and D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may not include more recent developments.)

BACKGROUND

Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

1. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task Force:

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

Then at the AMA 2025 Annual Meeting, the HOD adopted Policy D-5.995, "Protecting Access to Emergency Abortion Care Under EMTALA," which states:

2. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate

Care Is Banned or Restricted," will provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.

DISCUSSION

Task Force Formation

As directed by the HOD and in response to the 2022 U.S. Supreme Court's landmark decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (the Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board instructed that the Task Force would advise the Board of new and emerging threats to the provision of evidence-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the AMA Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. At that time, the Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with the underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report of the Task Force) that asked about priorities and capacity to engage on the issues identified in Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Society for Reproductive Medicine
- American Society of Clinical Oncology
- The Endocrine Society

The participating state medical associations include:

- California Medical Association
- Idaho Medical Association
- The Maryland State Medical Society (MedChi)
- Massachusetts Medical Society
- Pennsylvania Medical Society
- Texas Medical Association
- Medical Society of Virginia

In total, there are 29 physician members on the Task Force.

Overview of Task Force Meetings

As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identified implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identified potential resource gaps. The landscape analyses were presented to Council representatives monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

Since its inception in spring of 2024, the Task Force has held six virtual meetings, four in-person meetings, and three informational sessions. The virtual meetings were held in May 2024, December 2024, January 2025, May 2025, October 2025, and December 2025. This total does not include additional virtual meetings conducted with Task Force subcommittees or project teams. In-person meetings were held in July 2024, February 2025, July 2025, and February 2026. The informational sessions were held at the AMA 2024 Interim Meeting in November 2024, the AMA 2025 Annual Meeting in June 2025, and the AMA 2025 Interim Meeting in November 2025.

<u>Virtual Task Force Meetings</u>

In 2024, the Task Force held two virtual meetings for all members of the Task Force. The Task Force held a virtual kick-off meeting in May 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the Task Force held a meeting to discuss the remarks given at the informational session at the 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects.

In 2025, the Task Force held virtual meetings on a quarterly basis. First, in January 2025, the Task Force met to review research conducted into strategy and messaging. (Note: Additional details about the research discussed in the January meeting are provided later in this report.) Then, in May of 2025, the Task Force met to discuss emerging research into the impact of abortion bans and restrictions on the workforce. Then, at the Task Force's fifth virtual meeting in October of 2025, the Task Force met to review and provide feedback on the resource hub the Task Force developed. (Note: Additional details about the resource hub created by the Task Force are provided later in this report.) Finally, at the Task Force's sixth virtual meeting in December 2025, the Task Force met to discuss American College of Obstetricians & Gynecologists (ACOG)'s project to develop and implement state-specific guidance and protocols at institutions in states banning or restricting abortion. (Note: Additional details about the project discussed in the December meeting are provided later in this report.)

In addition to the six virtual meetings with all members of the Task Force, numerous virtual meetings for various Task Force subcommittees and project teams were also held to coordinate ongoing projects, prepare for upcoming meetings with external stakeholders, and ensure that project milestones were met.

In-Person Task Force Meetings

Over the course of two years, the Task Force held four all-day, in-person meetings at the AMA Headquarters in Chicago. These meetings were structured to focus the Task Force's attention on the specific aspects of abortion care impact by *Dobbs* and gender-affirming care, as laid out in AMA Policy G-605.009. Nationally recognized experts in legal issues, payment and reimbursement for gender-affirming care in adult patients, medical education and training, and public health and health outcomes equipped Task Force members with the latest information, research, data, and resources. These presentations and discussions supplemented Task Force members clinical expertise, supporting discussions to identify relevant resource gaps and opportunities to fill them.

The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers. Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instructed the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent the following nine organizations:

- AMA Board of Trustees
- AMA Council on Legislation
- AMA Council on Ethical and Judicial Affairs
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Psychiatric Association
- American Society for Reproductive Medicine
- The Endocrine Society
- Idaho Medical Association

AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and helped inform discussion during in-person meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement

for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's meeting in February 2025 dedicated to these issues.

One of the issues identified by the subcommittee was challenges arising from CPT® coding for gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section to field a survey to better understand these coding challenges. The input from this survey aided the Task Force's discussion of coding issues during its February 2025 meeting.

As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care." The meeting featured a range of speakers on topics all involving payment and reimbursement limitations and administrative challenges that impede access to gender-affirming care for adults, including challenges stemming from limited or non-specific billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and policies, and state and federal efforts to restrict or criminalize access to gender-affirming care. Speakers included physicians who provide gender-affirming care to adult patients, attorneys, coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to allow ample time after each presentation for Task Force members to ask questions of the presenters and discuss barriers to care with one another. These discussions focused on the current landscape and highlighted potential pain points for physicians and patients. Much of the discussion also centered around recent federal executive orders to prohibit federal funding of services for minors and the impact those policies could have on care for other populations. In the last session of the meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task Force to recommend solutions to these barriers to care, the Task Force members discussed opportunities and strategies for improving access to care and alleviating administrative burden, including working towards creating more specific CPT codes, where appropriate, continuing to advocate against criminalization, and supporting physicians who care for transgender and gender diverse patients. This discussion was informed by Task Force members' perspectives as clinicians, the speaker presentations, and discussions throughout the meeting.

In July 2025, the Task Force held its third in-person meeting. Featuring nine speakers across four sessions, the meeting's agenda focused on the impact of medical care restrictions on medical education, training, and the physician workforce. In the first session of the morning, speakers from the Accreditation Council on Graduate Medical Education (ACGME) examined program requirements, challenges facing training programs, and the impact of abortion restrictions on clinical training. The meeting's second session explored opportunities to expand clinical training options for trainees, including how programs are adapting to the post-*Roe* environment and how the legislative landscape is impacting clinical training in gender-affirming care. During the meeting's third session, Task Force members heard from a resident and two medical students about the challenges they are facing, how abortion care restrictions are impacting residents and medical students' educational opportunities, and how the current legislative landscape is affecting LGBTQ+ residents and medical students' medical education. In the meeting's last session, speakers from the American Association of Medical Colleges (AAMC) discussed the impact of abortion restrictions on medical schools and the physician workforce pipeline, highlighting research into changes in residency applications in states with abortion restrictions. During the final session of the meeting, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

The Task Force held its fourth and final all-day, in-person meeting in February of 2026. The goal of the Task Force's fourth meeting was to examine the intersection of abortion and public health and identify and evaluate available resources to help physicians and medical students navigate those issues. Invited speakers across four discussions and presentations focused the conversation on various facets of public health or health care delivery and the challenges faced by physicians, medical students, and patients in that space. The meeting's agenda included a discussion on the current political and legal landscape, a presentation on *Dobbs'* impact on health care delivery and health outcomes, a presentation on issues and disparities in medication abortion access, and a presentation on the impact of *Dobbs* on medical liability and population health. Following each presentation, the Task Force asked questions of the presenter, discussed the issues raised, and discussed resources available or needed to support physicians and medical students.

Informational Sessions

In accordance with AMA policy, which directs the Task Force to present updates of its findings including policies, strategies, and resources, the Task Force hosted a series of informational sessions at Annual and Interim meetings of the HOD. These informational sessions served to facilitate engagement with AMA Delegates, Alternate Delegates, and representatives from the AMA Sections and to elevate important voices that are not members of the Task Force.

The Task Force hosted its first informational session at the AMA's 2024 Interim Meeting. At the session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in 2024. Following the presentation, selected representatives from the AMA's Sections were invited to provide remarks about their experience with laws restricting or banning reproductive health care. The representatives' remarks focused on state laws' impacts on patient care, career and family decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician stress and anxiety. The selected speakers from the AMA Sections represented:

- Women Physicians Section
- Medical Student Section
- Resident and Fellow Section
- Young Physicians Section
- Minority Affairs Section
- LGBTQ+ Section
- Private Practice Physician Section
- Organized Medicine Staff Section
- Academic Physicians Section
- International Medical Graduates Section
- Senior Physician Section

After the representatives from AMA's Sections spoke, AMA Delegates, Alternate Delegates, and other interested parties were invited to ask questions or provide remarks on issues being considered by the Task Force that had not been addressed by previous speakers. These speakers focused their remarks on requests for more communication about the Task Force's work and opportunities for future engagement with the Task Force.

Then at the Annual Meeting of the HOD in June of 2025, the Task Force hosted its second informational session. The purpose of the informational session was to continue engagement with the AMA Delegates, Alternate Delegates, Council members, representatives from AMA Sections and other interested parties. During the informational session, the Task Force showcased some of the research and resources it has developed to support physicians navigating the post-*Roe* legal

landscape. The highlighted resources included a presentation on messaging strategy and a presentation on the legal assistance available from the Abortion Defense Network. (Note: Additional details about the messaging strategy and the legal assistance resources are provided later in this report.) In addition, the informational session included a question-and-answer portion to provide an opportunity to ask questions of the Task Force and an opportunity to share perspectives on its work. The perspectives shared by Delegates, Alternate Delegates, representatives from AMA Sections and other interested parties at the informational session were informative, shaping how the Task Force approached its ongoing work.

Once again at the Interim meeting of the HOD in November of 2025, the Task Force hosted a third informational session to facilitate resource-sharing and engagement with AMA Delegates, AMA Alternate Delegates, Council members, representatives from AMA Sections, and other interested parties. At this informational session, the Task Force launched its website: the Reproductive Health Resource Navigator, which is a resource hub for physicians navigating abortion bans and restrictions. (Note: The Reproductive Health Resource Navigator is available at https://www.rhrnavigator.org/. Additional details about the Reproductive Health Resource Navigator are provided later in this report.) Following a demonstration and overview of the website, invited speakers gave presentations on resources their organizations offer to physicians, residents, and medical students. Repeatedly in conversations with AMA Sections and other interested parties, the Task Force has heard about the need for legal assistance for physicians navigating the post-*Roe* legal landscape. In response, at the informational session the Task Force hosted the Abortion Defense Network to present on the legal assistance, representation, and legal defense funding that they provide to physicians navigating the post-*Roe* legal landscape. Then during their presentation, the Ryan Residency Training Program examined the current clinical training landscape and discussed their efforts to provide out-of-state clinical training opportunities to residents in states with abortion bans and restrictions.

In the last portion of the informational session, attendees were invited to ask questions of the presenters and share their perspectives on the work of the Task Force. This engagement from attendees was extremely important to the Task Force and ensured that the perspectives and experiences from members of the HOD and AMA Sections are considered in the work of the Task Force. These remarks highlighted important requests and concerns for the Task Force to address in its work. As it contemplates its work in 2026, the Task Force reaffirms its commitment to ensuring underrepresented voices continue to be uplifted through its work.

Task Force Outreach

In addition to the informational sessions, the Task Force conducted outreach with any interested AMA Sections, AMA Councils, and specialty groups in the lead up to the past three HOD meetings and met with the groups at their request. As part of this outreach, the Task Force met with AMA's Council on Legislation, Council on Medical Service, and ACOG's delegation to the HOD. In addition, these meetings facilitated open communication and provided a forum for valuable dialogue with AMA Sections, including the AMA Women Physicians Section, AMA LGBTQ+ Section, AMA Academic Physicians, and AMA Medical Students Section. The perspectives shared during these meetings were critical in shaping the Task Force's work and ensuring that pressing needs, requests, and concerns are addressed. For example, as part of this engagement and to address concerns raised during these discussions, the Task Force partnered on a survey with the LGBTQ+ Section that focused on physician well-being and informed the development of well-being resources.

Ongoing Projects of the Task Force

As a result of reproductive care resource gaps identified by the Task Force, and at the direction of the Board, AMA staff has undertaken a series of projects and initiated partnerships and collaborations to fill those gaps.

Reproductive Health Resource Navigator

In accordance with the directive to identify and create implementation-focused practice and advocacy resources, the Task Force recommended that AMA develop a website, the Reproductive Health Resource Navigator, to serve as a resource hub for physicians navigating abortion bans and restrictions. The AMA agreed that this was a priority and supported the funding of its development. The website is publicly available at https://www.rhrnavigator.org/. The Reproductive Health Resource Navigator houses more than 300 resources developed by the Task Force, AMA, state medical associations and national medical specialty societies, and external organizations. The resources address legal considerations, clinical care, practice management, medical education, and patient resources and are organized in by topic in a searchable format. In accordance with the directive in Policy D-5.995 to provide resources to assist physicians navigating conflicting state and federal regulations on emergency pregnancy care, the site also includes guidance on complying with EMTALA obligations. Additionally, legal representation resources and physician well-being resources are highlighted for site visitors.

Public Opinion Research and Messaging

To support coordinated advocacy, effective engagement, and in accordance with the directive to guide organized Medicine's response to abortion restrictions, the Task Force recommended AMA commission qualitative public opinion research using surveys, in-depth interviews, and focus groups. The research helped explain how different messages, language, and tone resonate across key constituent audiences and build a more compelling narrative for reproductive health advocacy grounded in a strategic messaging foundation. The research provided insight for Task Force members and their organizations on physicians' and the public's perception of the current reproductive health care landscape and will inform strategy for the Task Force going forward. The Task Force met in January 2025 to review the research findings. Findings were also shared with Task Force member organizations and other Federation of Medicine partners.

Research on the Workforce Impact

To better understand how abortion bans and restrictions impact the physician workforce and to carry out the directive that the Task Force monitor workforce impacts, the Task Force recommended AMA conduct research on the impact of abortion bans and restrictions on the physician workforce and again, the AMA agreed to fund this research. Accordingly, AMA staff initiated a research project examining the impact of abortion restrictions on the physician workforce and where physicians choose to practice. The research and mapping project was completed in spring 2025 and the findings were presented to Task Force members during its virtual meeting in May of 2025.

Legal Assistance and Resources for Physicians

In accordance with the directive to publicize resources for physicians to connect with legal assistance and to protect physicians against civil or criminal prosecution, the Task Force worked with the AMA to support the Abortion Defense Network (ADN) and their network of attorneys and

law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal landscape. ADN's resources are available to physicians and other health care providers at www.abortiondefensenetwork.org. Their resources include 26 in-depth "Know Your State's Abortion Laws" guides for medical professionals, which aim to provide clarification on what conduct is permitted and what the law requires in states with abortion restrictions. The partnership between the Task Force and ADN resulted in 10 additional state law guides (Alabama, Arizona, Mississippi, Montana, Nevada, New Hampshire, North Dakota, South Dakota, Virgina, and West Virgina). The guides cover state laws and professional guidelines on numerous facets of reproductive health care, including medication abortion, contraception, and obligations under EMTALA. The state law guides are available on the ADN's website at https://abortiondefensenetwork.org/resources/providers/.

In addition to their written legal resources, ADN connects physicians and others involved in providing abortion care with personalized legal advice and financial assistance. The Task Force urged AMA to support greater physician access to legal assistance, representation, and legal defense funding to physicians navigating the post-*Roe* legal landscape. AMA agreed and provided financial assistance to ADN. Physicians and medical professionals seeking personalized legal assistance can contact ADN using their online form at https://abortiondefensenetwork.org/get-in-touch/. After submitting the form, physicians and medical professionals can expect a response from an attorney within 24 hours. ADN's legal assistance is typically provided *pro bono*. In instances where additional legal funding assistance for a civil or administrative action is needed, physicians and medical professionals may be able to access legal defense funds through ADN.

Through 2025 and 2026, AMA staff has continued regular meetings with ADN to discuss opportunities to collaborate, publicize, and promote ADN's legal services and resources. In addition, these meetings have covered the development of additional ADN resources, including "Know Your Rights" one-pagers and resources related to EMTALA.

Institution-level Guidance

In accordance with a directive adopted at the 2024 Interim Meeting instructing the Task Force to work with interested parties to encourage the development of institution-level guidance, the Task Force is collaborating with ACOG to promote adoption of state-specific, institution-level guidance for managing pregnancy-related medical emergencies in states with abortion restrictions. Using sample protocols drafted by ACOG with support from Lawyers for Good Government, this initiative clarifies institutional policies on abortion to ensure pregnant patients receive appropriate medical care in compliance with state law.

The institutional guidance project is a joint initiative of ACOG and Lawyers for Good Government, with support from the Society for Maternal-Fetal Medicine and the AMA. At ACOG's request, the AMA added a statement of support to ACOG's protocol materials. ACOG also requested the AMA help make connections with individuals and organizations who could help support adoption of the protocol. To further the initiative, the AMA's role has been to support the targeted and intentional promotion of the project, identify champions to advance the protocols at their own institutions, and connect ACOG to relevant state-level contacts. To accomplish this, the AMA facilitated convenings and information sharing with relevant state medical associations, the AMA's Organized Medical Section, and the AMA's Integrated Physician Practice Section. AMA is eager to continue supporting ACOG in the implementation of this project and looks forward to the continued collaboration.

Collaboration with Elected Prosecutors and District Attorneys

To gain clarity on how abortion bans may be enforced against physicians, and in accordance with AMA policy to protect against civil, criminal, and professional liability and retaliation, the Task Force identified an opportunity to engage with an organization representing elected prosecutors and district attorneys nationwide. The AMA agreed that this would be a productive use of time and resources and, as a result, in March of 2025, seven Task Force members participated in a full day convening with elected prosecutors from around the country. The convening helped professionals on each side understand the others' perspectives, processes, and challenges, and brainstorm strategies to mitigate risk of prosecution for physicians providing abortion care under exceptions in state law. Following the March meeting, a local convening modeled after the national meeting was held. This meeting convened local prosecutors, state legislators, and local physician leaders.

Continuing the collaboration, a new group of seven Task Force members attended a second convening with the national prosecutors' group in December of 2025. As a result of this meeting, the Task Force and participating prosecutors are planning two upcoming webinars to educate both prosecutors and physicians. Specifically, one webinar will educate physicians about the criminal prosecution process and relevant legal standards; the other webinar will educate prosecutors about pregnancy complications and the incompatibility between abortion laws and clinical practice. This work is on-going. (Note: This report was prepared in February and may not include more recent developments.) The AMA is continuing to collaborate with prosecutor groups to educate the prosecution field and establish collaborative relationships to help inform prosecutorial actions.

Support for Residents and Medical Students

As a result of the Task Force's discussions on challenges and barriers facing medical students and residents, and in accordance with AMA policy to mitigate radically diminished training opportunities, AMA staff initiated several projects and collaborations to support residents and medical students navigating bans and restrictions on abortion. The Task Force recommended that the AMA provide financial assistance to facilitate out-of-state training opportunities. The AMA agreed and helped fund the UCSF Ryan Residency Training Program in order to provide financial assistance to enable residents in ban states to travel to out-of-state institutions for abortion training, support for institutions who receive out-of-state residents, and build capacity within the Ryan Residency Training Program to further support institutional partnerships to ensure availability of abortion training.

All OB-GYN residency programs are required by ACGME to provide training in abortion care. In states where abortion is banned or severely restricted, residency programs cannot fulfill this requirement without sending residents to external sites. Many institutions, particularly in the South and Midwest, report that they lack resources or face legal or policy barriers to funding residents' travel, leaving residents personally responsible for those costs. The AMA's financial assistance for resident travel costs help to fill that gap, ensuring that residents are able to accept temporary placement and gain competency in managing abortion, miscarriage, and pregnancy complications.

A critical barrier to maintaining out-of-state training partnerships is the strain placed on the clinical sites that host visiting residents. These receiving institutions must absorb significant administrative, supervisory, and logistical burdens, from processing temporary licenses, malpractice coverage, and onboarding requirements to adjusting clinic schedules and supervision ratios to accommodate additional trainees. Many are safety-net or academic centers already operating at capacity. The Ryan Program will provide direct financial and technical support to these host institutions, helping offset the costs of integrating visiting residents while preserving high-quality training for all

learners. By supporting receiving institutions, the contribution will help ensure these cross-state partnerships remain sustainable for receiving institutions.

While short-term funding for resident placements is urgently needed, the Ryan Program's broader infrastructure helps make those rotations possible. The Ryan Program serves as the central convener and technical resource for residency programs navigating legal, logistical, and educational complexities in the post-*Dobbs* environment. The AMA's funding helped enable the program to expand and formalize these efforts by developing standardized affiliation agreements, refining compliance and risk-management tools, facilitating communication between sending and receiving sites, and building the capacity of faculty and program administrators to manage these cross-state collaborations effectively. This investment ensures that the national system for arranging out-of-state training is scalable and sustainable for the future.

Lastly, in response to the Task Force's discussions on moral distress, trainee mental health, and the need to support medical student well-being, the AMA published two issue briefs on moral distress in medical students, available resources, and AMA policies to support medical student well-being. These issue briefs are available at https://www.ama-assn.org/system/files/Issue-brief-moral-distress.pdf and https://www.ama-assn.org/system/files/issue-brief-med-student-resources.pdf.

The Task Force continues to consider additional deliverables to support physicians navigating state laws restricting or banning abortion.

CONCLUSION

The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-26

Subject: Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates

Presented by: Jerry P. Abraham, MD, MPH, Chair

The Council on Constitution and Bylaws (CCB) submitted CCB Report 3-I-25 to the House of Delegates (HOD) for consideration. The report drew extensive testimony in the online reference committees. The Reference Committee on Ethics and Bylaws in its preliminary report had difficulty with a report this complex and nuanced, particularly as online testimony included various amendments. After reviewing the preliminary report that contained 21 recommendations, CCB reviewed the extensive online testimony, proposed amendments, and the preliminary reference committee report, and submitted a revised report reflecting some of the testimony and amendments in the hopes that the revised report would be easier to manage at the reference committee hearing. Ultimately, after extensive debate on multiple aspects of the report, the HOD referred the report back to CCB for a report at A-26, along with Resolution 10-I-25. The resolution from the Medical Student (MSS) and the Resident and Fellow (RFS) Sections asked that the bylaws be amended to explicitly allow these sections to appoint rather than elect individuals to serve as temporary delegates and alternate delegates to fill vacancies and absences.

Admittedly, CCB Report 3-I-25 was a lengthy report that touched on a myriad of topics, many of which were nuanced. As the Council discussed appropriate follow-up, it determined that to make its proposed amendments more easily digestible and manageable for HOD members and the reference committee at A-26, it was preferable to issue a series of shorter reports, each focusing on a distinct issue addressed in CCB 3-I-25 and Resolution 10-I-25. For each report, the Council has also included the final clean bylaw language if the report is adopted. Included as an appendix to this report is a clean copy of the affected provisions of Bylaw 2 (Appendix B) if CCB 2-7 reports were adopted. Additionally, the Council has included as an appendix (Appendix A) a taxonomy of the existing and amended bylaw changes, and the source CCB report of those changes. Lastly, Appendix C includes a chart with links to the Bylaws of all entities with HOD representation for easy reference.

Report topics are as follows:

- CCB Report 2, HOD Representation and Composition
  - This report provides some amended language to emphasize the inclusive nature of the HOD.
- CCB Report 3, Rights & Privileges of HOD Members
  - This report explicitly sets forth the rights and privileges afforded to delegates paralleling existing bylaw language that articulates the rights and privileges of the alternate delegates, ex officio members, official observers, and temporary delegates.
- CCB Report 4, Credentialing of HOD Delegates and Alternate Delegates
  - This report identifies the appropriate credentialing authority for all entities represented in the HOD, respecting the unique nature of the section HOD delegates and alternates, medical student regional delegates and alternates and the resident and fellow sectional

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delegates and alternates. The updated term ‘credentialing’ replaces ‘certification’ which refers to a process that is no longer utilized. Lastly, some existing language is clarified for accuracy and consistency.

- CCB Report 5, Inclusion of Medical Students and Resident/ Fellow Physicians in HOD Delegations
  - This report reinstates language proposed for deletion in CCB 3-1-25, language which states that a medical student or a resident/fellow may be hold a constituent association delegation seat. It also establishes an equivalent ability for the national medical specialty societies and professional interest medical associations to seat a medical student or a resident/fellow as delegation members.
- CCB Report 6, Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates
  - This report addresses the bylaws associated with the medical student regional delegates and alternate delegates and resident and fellow sectional delegates and alternate delegates, including their eligibility for election, the mechanism by which they are elected, and their unique seating assignment in the HOD.
- CCB Report 7, HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
  - This report eliminates the confusing distinction between a substitute delegate and a temporary substitute delegate and specifies the process by which a vacancy may be filled after the credentialing deadline, and the process to fill an open seat due to a meeting absence. This report also addresses Resolution 10-I-25 by granting the sections the ability to credential a temporary delegate or temporary alternate delegate when there are no available elected alternate delegates.

The Council hopes that by separating these complex and nuanced issues the AMA Bylaws will be amended in accordance with the will of the HOD.

TAXONOMY OF AMA BYLAWS SECTION 2 IMPACTED BY CCB REPORTS 2-7 (Provisions 2.0.1 through 2.10)

CCB 2, HOD Representation and Composition
CCB 3, Rights & Privileges of HOD Members
CCB 4, Credentialing of HOD Delegates and Alternate Delegates
CCB 5, Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
CCB 6, Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates
CCB 7, HOD Delegate and Alternate Delegate Vacancies and Meeting Absences

Existing Bylaws	**Amended Bylaws**	**Source of Proposed Amended Bylaws and Comments**
2.0.1 Composition and Representation	**2.0.1 Composition and Representation**	**CCB 3** – Incorporates language on alternate delegates (previously section 2.8) into this section for completeness; new text specifies the rights and privileges of delegates.
2.0.1.1 Qualifications of Members of the House of Delegates	2.0.1.1 Qualifications of Members of the House of Delegates	**CCB 2** – Emphasizes inclusion of medical students and residents and fellows; spells out the rights and privileges of delegates.
2.0.1.2 Representation	2.0.1.2 Representation	**CCB 2** – Acknowledges resident and fellows and medical students are represented in the HOD
2.0.1.2.1 Consideration	2.0.1.2.1 Consideration	**CCB 2** – Acknowledges a need to consider the perspective of medical students in addition to the perspectives of their patients, their sponsoring organizations and their physician constituents.
(formerly 2.8)	2.0.1.3 Alternate Delegates	**CCB 2** – Acknowledges each society is allotted an alternate delegate for each delegate, with the alternate delegate needing to meet the criteria of 2.0.1.1 and be credentialed in accordance with how the delegate is credentialed.
(formerly 2.8.5 and 2.8.6)	2.0.1.3.1 Rights and Privileges.	**CCB 3** – Deletes redundant and obsolete language; edits for accuracy.

(formerly 2.8.6 and 2.8.6)	2.0.1.3.2 Alternate Delegate Seated for a Delegate	**CCB 3** – Deletes redundant and obsolete language; edits for accuracy; specifies the rights of an alternate delegate seated for a delegate.
(formerly 2.10.7)	2.0.1.4 Unique Representation	**CCB 2** – Retitled to address representation by an individual of only a single society
(New)	2.0.1.5 Registration	**CCB 2** – Specifies the need for every attendee to register for HOD meetings
2.0.1.3 Autonomy	2.0.1.6 Autonomy	**CCB 2** – Numbering change
2.1 Constituent Associations	**2.1 Constituent Association Delegations**	**CCB 2** – Edits for consistent terminology across all represented societies
2.1.1 Apportionment	2.1.1 Apportionment	**CCB 2** – Edits for accuracy; acknowledges the inclusion of AMA member medical students and residents in membership count
2.1.1.1 Effective Date	2.1.1.1 Effective Date	**CCB 2** – Incorporates language from former 2.10.1
2.1.2 Selection	2.1.2 Selection	**CCB 5** – Edits for accuracy
2.1.3 Certification	2.1.3 Credentialing	**CCB 4** – Edits for accuracy
2.1.4 Term	2.1.4 Term	**CCB 2** – Edits for completeness and accuracy
2.1.5 Vacancies	2.1.5 Vacancies	**CCB 7** – Edits for completeness and accuracy delegates
2.1.6 Resident/Fellow Physician and Medical student Delegates	2.16. Resident and Fellow Physician and Medical Student Delegates and Alternate Delegates	**CCB 5** – Edits for accuracy and to parallel language for medical student regional delegates and alternate delegates
2.1.6.1 Term	2.1.6.1 Term	**CCB 5** – Edits for accuracy
2.1.6.2 No Restriction on Selection	2.1.6.2 No Restriction on Selection	**CCB 5** – Edits for accuracy
2.1.7 Application by a Constituent Association for Representation in the House of Delegates	2.1.7 Application by a Constituent Association for Representation in the House of Delegates	No changes
2.2 National Medical Specialty Societies.	**2.2. National Medical Specialty Society Delegations**	**CCB 2** – Edits for consistent terminology across all represented societies
2.2.1 Apportionment	2.2.1 Apportionment	**CCB 2** – Edits for accuracy; acknowledges the inclusion of AMA member residents and fellows in apportionment membership count.
2.2.1.1 Effective Date	2.2.1.1 Effective Date	**CCB 2** – Incorporates language from existing 2.10.1
2.2.2 Selection	2.2.2 Selection	**CCB 5** – Edits for accuracy

2.2.3 Certification	2.2.3 Credentialing	**CCB 4** – Edits for accuracy
2.2.4 Term	2.2.4 Term	**CCB 2** – Edits for completeness and accuracy
2.2.5 Vacancies	2.2.5 Vacancies	**CCB 7** – Edits for completeness and accuracy delegates
(New)	2.2.6 Resident and Fellow Physician and Medical Student Delegates and Alternate Delegates	**CCB 5** – Acknowledges a specialty society can credential a medical student or resident/fellow
(New)	2.2.6.1 Term	**CCB 5** – Acknowledges a specialty society can credential a medical student or resident/fellow for a one year term
(New)	2.6.2.2 No Restriction on Selection.	**CCB 5** – Acknowledges a specialty can credential a medical student or resident/fellow for a (full) two-year term
2.3 Medical Student Regional Delegates	**2.3. Medical Student Regional Delegates and Alternate Delegates**	**CCB 6** – Edits for consistent terminology across all represented societies
2.3.1 Qualifications	2.3.1 Qualifications	**CCB 6 –** Edits for accuracy. Existing language from 2.3.3 on the need for endorsements included here for completeness.
2.3.2 Apportionment	2.3.2 Apportionment	**CCB 6** – Edits for accuracy
2.3.2.1 Effective Date	2.3.2.1 Effective Date	**CCB 6 –** Edits for accuracy
2.3.3 Election	2.3.3 Election	**CCB 6** – Edits for accuracy and to eliminate redundancy; clarifies that the student members of Regions elect the delegates and alternate delegates at the section's business meeting in conjunction the Interim HOD meeting, with elected students assuming their office at the subsequent next HOD meeting.
2.3.4 Certification	2.3.4 Credentialing	**CCB 4** – Edits for accuracy
2.3.5 Term	2.3.5 Term	**CCB 7** – Deletes redundant language related to credentialing
2.3.6 Vacancies	2.3.6 Vacancies	**CCB 7** – Edits for completeness and accuracy delegates
(formerly 2.10.8)	2.3.7 Medical Student Seating	**CCB 6** – Included here for completeness; edits for accuracy.
2.4 Delegates from the Resident and Fellow Section	**2.4 Resident and Fellow Sectional Delegates and Alternate Delegates**	**CCB 6** – Edits for consistent terminology across all represented societies

2.4.1 Qualifications	2.4.1 Qualifications	**CCB 6 –** Edits for accuracy Existing language from 2.4.3 on the need for endorsements included here for completeness.
2.4.2 Apportionment	2.4.2 Apportionment	**CCB 6** – Edits for accuracy
2.4.2.1 Effective Date	2.4.2.1 Effective Date	**CCB 6** – Edits for accuracy
2.4.3 Election	2.4.3 Elections	**CCB 6** – Edits for accuracy and to eliminate redundancy; clarifies that elections are held at the section's business meeting held in conjunction with the Interim HOD meeting, with elected residents and fellows assuming their office at the subsequent HOD meeting.
2.4.4 Certification	2.4.4 Credentialing	**CCB 4**—Edits for accuracy
2.4.5 Term	2.4.5 Term	**CCB 6** – Edits for accuracy
2.4.6 Vacancies	2.4.6 Vacancies	**CCB 7** – Edits for completeness and accuracy
(formerly 2.10.9)	2.4.7 Resident and Fellow Seating	**CCB 6** – Included here for completeness; edits for accuracy,
2.5 Speaker and Vice Speaker Additional Delegate	**2.5 Speaker and Vice Speaker Additional Delegates**	**CCB 3** – Edits for consistency and accuracy
2.5.1 Status of Speaker and Vice Speaker	2.5.1 Rights and Privileges	**CCB 3** – Retitled Rights & Privileges
2.5.2 Term	2.5.2 Term	No changes
2.6 Other Delegates	**2.6 Other Delegates and Alternate Delegates**	**CCB 2** – Edits for consistent terminology across all represented societies
2.6.1 Certification	2.6.1 Credentialing	**CCB 4** – Edits for accuracy
2.6.2 Term	2.6.2 Term	**CCB 2** – Edits for completeness and accuracy; **CCB 4** – Deletes language redundant to that in 2.6.1.
(new)	2.6.2.1 Resident/Fellow Physician and Medical Student Delegates	**CCB 5** – Acknowledges ability of these groups to credential a medical student or resident/fellow
(new)	2.6.2.1.1	**CCB 5 –** Acknowledges these groups can credential a medical student or resident/fellow for a one year term
(new)	2.6.2.1.2	**CCB 5** – Acknowledges these groups can credential a medical student or resident/fellow for a (full) two-year term

2.6.3 Vacancies	2.6.3 Vacancies	**CCB 7** – Edits for completeness and accuracy delegates
	2.6.4 No Restriction on Selection	**CCB 5** – Acknowledges a medical student or resident and fellow physician may serve a full two-year term
2.7 Ex Officio Members	**2.7 Ex Officio Members**	No changes
2.7.1 Rights and Privileges	2.7.1 Rights and Privileges	No changes
2.8 Alternate Delegates	**---**	**CCB 2** – Incorporated into new 2.0.1.3 with edits for completeness and accuracy
2.8.1 Qualifications	---	**CCB 3** – Deleted as existing language was incorporated in updated delegation language for each represented society
2.8.2 Certification	---	**CCB 3** – Existing language was incorporated in updated delegation language for each represented society
2.8.3 Term	---	**CCB 3** – Existing language was incorporated in updated delegation language for each represented society
2.8.4 Vacancies	---	**CCB 3** – Existing language was incorporated in updated delegation language for each represented society
2.8.5 Rights and Privileges	(now 2.0.1.3.1)	**CCB 3** – Alternate delegate status retitled as rights and privileges; combined with 2.8.6. with edits for accuracy.
2.8.6 Status	(now 2.0.1.3.2)	**CCB 3** – see above
---	**2.8 Additional Alternate Delegates (new heading)**	**CCB 3** – New Heading
(formerly 2.10.5)	2.8.1 Constituent Association President	**CCB 3** – Edits for accuracy
(formerly 2.10.6)	2.8.2 National Medical Specialty Society or Professional Interest Medical Association President	**CCB 3** –Edits for accuracy
2.9 Official Observer	**2.9 Official Observer**	No changes
2.9.1 Rights and Privileges	2.10.1 Rights and Privileges	No changes
2.10 Registration and Seating of Delegates	**2.10 Temporary Delegates and Alternate Delegates**	**CCB 7** – Retitled
2.10.1 Notification	---	**CCB 2** – Eliminates redundant language
2.10.2 Credentials	---	**CCB 7** – Eliminates redundant language
2.10.3 Lack of Credentials	---	**CCB 7** – Eliminates redundant language

2.10.4 Substitute		**CCB 7** – Incorporated into new 2.10.2
2.10.4.1 Temporary Substitute Delegates	---	**CCB 7** – Deletes obsolete language
(new)	2.10.1 Temporary Delegates	**CCB 7** – A credentialing authority may credential a temporary delegate
(new)	2.10.1.1	**CCB 7** – A delegate not credentialed by the credentialing deadline may be credentialed as a temporary delegate
(new)	2.10.1.2	**CCB 7** – An alternate delegate may be credentialed as a temporary delegate when the delegate is unavailable
(new)	2.10.1.3	**CCB 7** – A temporary alternate delegate may be credentialed as a temporary delegate when an delegate is unavailable
(new)	2.10.1.4	**CCB 7** – Temporary delegates must be credentialed the day before an AMA election in order to vote
(new)	2.10.2 Temporary Alternate Delegates	**CCB 7** – A credentialing authority may credential a temporary delegate
(new)	2.10.2.1	**CCB 7** – An alternate delegate not credentialed by the credentialing deadline may be credentialed as a temporary alternate delegate
(new)	2.10.2.2	**CCB 7 -**– An entity's member may be credentialed as a temporary alternate delegate when an alternate delegate is unavailable
(new)	2.10.2.3 Temporary Medical Student Regional Alternate Delegate	**CCB 7** – A medical student may be credentialed as a temporary regional alternate delegate when a regional alternate delegate is unavailable.
(new)	2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate	**CCB 7** – A resident and fellow may be credentialed as a temporary sectional alternate delegate when a sectional alternate delegate is unavailable.
2.10.5 Constituent Association President	(now 2.8.1)	**CCB 3** –Language now under new heading Additional Alternate Delegates for better organization

2.10.6 National Medical Specialty Society or Professional Interest Medical Association President	(now 2.8.2)	**CCB 3** – Language now under new heading Additional Alternate Delegates for better organization
2.10.7 Representation	(now 2.0.1.3)	**CCB 2** –Incorporated into 2.0.1.3 for completeness
2.10.8 Medical Student Seating	(now 2.3.7)	**CCB 6** – Incorporated under the bylaws governing medical student regional delegates and alternate delegates
2.10.9 Resident and Fellow Seating	(now 2.4.7)	**CCB 6** – Incorporated under the bylaws governing resident and fellow sectional delegates and alternate delegates

CLEAN LANGUAGE FROM AMA BYLAWS SECTION 2, HOUSE OF DELEGATES (IF THE HOD ADOPTS THE RECOMMENDATIONS IN CCB REPORTS 2 THROUGH 7):

2—House of Delegates

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA, including resident and fellow physicians and medical students, and of the entity they represent.

2.0.1.2 Representation. The representational role of the delegates is multi-dimensional and includes:

a. Advocacy for patients to improve the health of the public and the health care system.

b. Representation of the perspectives of the delegate's sponsoring organization to the House of Delegates.

c. Representation of the delegate's physician and medical student constituents in the decision-making process of the House of Delegates.

d. Representation of the AMA and the House of Delegates to physicians, medical associations, and others, including resident and fellow physicians and medical students.

e. Solicitation of input from and provision of feedback to constituents.

2.0.1.2.1 Consideration. In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their medical student or physician constituents. In voting on matters before the House of Delegates, delegates should vote on the basis of what is best for patients and quality medical care.

2.0.1.3 Alternate Delegates. Each organization represented in the House of Delegates is allotted an alternate delegate for each of its delegates entitled to be seated in the House of Delegates. Alternate delegates must meet the criteria specified in Bylaw 2.0.1.1 and be similarly credentialed per the Bylaws that govern credentialing for the delegates representing their organization. Terms for alternate delegates shall be the same as for the delegates.

2.0.1.3.1–Rights and Privileges. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates~~,~~ or vote in any election conducted by the House of Delegates. An alternate delegate is

not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.0.1.3.2 Alternate Delegate Seated for a Delegate. At the request of their corresponding delegate, an alternate delegate may be seated for them on the floor of the House of Delegates. The alternate delegate must display their corresponding delegate's temporary credential (salmon badge). While seated for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates at the request of-their corresponding delegate.

2.0.1.4 Unique Representation. No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

2.0.1.5 Registration. All attendees of a House of Delegates meeting must register for the meeting.

2.0.1.6 Autonomy. The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

2.1 Constituent Association Delegations. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate and one alternate delegate for each 1,000 (or fraction thereof), active members of the AMA including medical students and residents and fellows within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

2.1.2 Selection. Each constituent association shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

2.1.3 Credentialing. The president or chief executive officer of each constituent association, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.1.4 Term. Delegates and alternate delegates from constituent associations shall be selected for two-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.1.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

2.1.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.1.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.

2.1.7 Application by a Constituent Association for Representation in the House of Delegates. A constituent association seeking representation in the House of Delegates shall submit an application to the AMA. The Board of Trustees shall make a recommendation to the House of Delegates as to the proposed constituent association's qualifications for representation, based on all the current guidelines for representation in the House of Delegates.

2.2 National Medical Specialty Society Delegations. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate and alternate delegate for each 1,000, or fraction thereof, physician specialty society members, including residents and fellows, as of December 31 of each year who are eligible to serve on committees or the governing

body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA.

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

2.2.2 Selection. Each specialty society shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

2.2.3 Credentialing. The president or chief executive officer of each specialty society, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.2.4 Term. Delegates and alternate delegates from specialty societies shall be selected for two-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate and alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.2.5 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

2.2.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates. A national medical specialty society may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.2.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.2.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.4.

2.3 Medical Student Regional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the constituent association where their educational program is located. The Medical Student Region in which the endorsing society is located determines the student's region,

and a medical student may only serve as a regional delegate, alternate delegate or a temporary delegate or temporary alternate delegate for that region.

2.3.2 **Apportionment.** The total number of medical student regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining medical student regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two Regions have the same number of active AMA medical student members, ties will be broken by lottery by the Medical Student Section Governing Council.

2.3.2.1 **Effective Date.** In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council and the Director of the Medical Student Section of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 **Election.** Medical student regional delegates and alternate delegates shall be elected by the medical student representatives to the appropriate Medical Student Region in accordance with rules adopted by the Medical Student Section and approved by the Board of Trustees. Regional delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section held in conjunction with the Interim Meeting of the House of Delegates. Regional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

2.3.4 **Credentialing.** The chair of the Medical Student Section Governing Council or the director of the Medical Student Section, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3. Credentialing must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.3.5 **Term.** Medical student regional delegates and alternate delegates shall be elected for one-year terms.

2.3.6 **Vacancies.** A medical student who fills a vacancy before the credentialing deadline as a medical student regional delegate or alternate delegate must be from the same medical student region as the vacating student and must be elected by that region. A medical student regional delegate or alternate delegate who fills such a vacancy shall assume office immediately after ~~s~~election and serve for the remainder of that term.

2.3.7 **Medical Student Regional Delegate Seating.** Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates, temporary delegates, or temporary alternate delegates shall be assigned to the original medical student regional delegate's seat location during the time they are seated for the original delegate.

2.4 Resident and Fellow Sectional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Resident and fellow sectional delegates and alternate delegates must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional delegates and alternate delegates must be members of and have written endorsement from a society or organization currently seated in the HOD, in a capacity appropriate to their level of training.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate and alternate delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.2.1 Effective Date. In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council and the Director of the Resident and Fellow Section of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.4.3 Election. Resident and fellow sectional delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with rules adopted by the Section and approved by the Board of Trustees. Sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section held in conjunction with the Interim Meeting of the House of Delegates. Sectional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

2.4.4 Credentialing. The chair of the Resident and Fellow Section Governing Council or director of the Resident and Fellow Section, or their designee, shall provide the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3. Credentialing of delegates and alternate delegates must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.4.5 Term. Resident and fellow sectional delegates and alternate delegates shall be elected for one-year terms.

2.4.6 Vacancies. A resident or fellow who fills a vacancy for a resident and fellow sectional delegate or alternate delegate before the credentialing deadline must be elected by the Resident and Fellow Section and shall assume office immediately after ~~s~~election and serve for the remainder of the term.

2.4.7 Resident and Fellow Sectional Delegate Seating. Each resident and fellow sectional delegate shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate sectional delegates, temporary delegates, or temporary alternate delegates shall be

assigned to the original resident and fellow sectional delegate's seat location during the time they are seated for the original delegate.

2.5 Speaker and Vice Speaker Additional Delegates. Upon election of the Speaker and Vice Speaker of the House of Delegates from among the members of the House of Delegates, the organizations represented by the delegates elected to be Speaker and Vice Speaker of the House of Delegates shall be entitled to an additional delegate for the term of service of the Speaker and Vice Speaker. The additional delegates so selected shall have the full rights and privileges of delegates in the House of Delegates.

2.5.1 Rights and Privileges. Upon their election, the Speaker and Vice Speaker shall continue to be members of the House of Delegates, with all of the rights and privileges of members of the House of Delegates. They shall be entitled to vote in the House of Delegates. The Speaker and Vice Speaker, as members of the House of Delegates, shall be eligible to be nominated for re-election to the office of Speaker and Vice Speaker of the House of Delegates.

2.5.2 Term. The delegates selected pursuant to this bylaw to serve during the term of service of the Speaker and Vice Speaker shall serve one-year terms consistent with the term of the Speaker and Vice Speaker. The organization represented by the delegate shall determine the tenure of the individual selected to serve.

2.6 Other Delegates and Alternate Delegates. Each of the following is entitled to a delegate and an alternate delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

2.6.1 Credentialing. The president, chief executive officer, AMA Section chair or director, or other authorized individual of each entity described in Bylaw 2.6 shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.6.2 Term. Delegates and alternate delegates from these entities shall be selected for two-year terms, and shall assume office on the date set by the entity.

2.6.2.1 Resident/Fellow Physician and Medical Student Delegates. These entities may designate their delegate and/or alternate delegate seat to be filled by a resident/fellow physician member or a medical student member.

2.6.2.1.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

2.6.2.1.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

2.6.3 Vacancies. The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

2.7 Ex Officio Members. The current Officers (except Speaker and Vice Speaker), the Past Presidents, Past Trustees of the AMA, and the Chairs of Councils of the AMA who are not delegates shall be ex officio members of the House of Delegates.

2.7.1 Rights and Privileges. Ex officio members have the right to speak and debate on the floor of the House of Delegates, but do not have the right to introduce business, introduce an amendment, make a motion, or vote.

2.8 Additional Alternate Delegates.

2.8.1 Constituent Association President. The current president of a constituent association may also be credentialed as an additional alternate delegate at the discretion of each constituent association.

2.8.2 National Medical Specialty Society or Professional Interest Medical Association President. The current president of a national medical specialty society or a professional interest medical association may also be credentialed as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

2.9 Official Observer. National organizations may apply to the Board of Trustees for official observer status in the House of Delegates. Applicants must demonstrate compliance with guidelines for official observers adopted by the House of Delegates, and the Board of Trustees shall make a recommendation to the House of Delegates concerning the application. The House of Delegates will make the final determination on the conferring of official observer status.

2.9.1 Rights and Privileges. Organizations with official observer status are invited to send one representative to observe the actions of the House of Delegates at all meetings of the House of Delegates. Official observers have the right to speak and debate on the floor of the House of Delegates upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

2.10 Temporary Delegates and Alternate Delegates.

2.10.1 Temporary Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.1 When there is no delegate credentialed by the 45-day credentialing deadline, a delegate who was appropriately selected via the entity's rules may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.2 When there is no appropriately selected delegate available an alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.3 When there is no appropriately selected alternate delegate available a temporary alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

2.10.1.4 Temporary delegates must be credentialed the day before an AMA election in order to vote in that election.

2.10.2 Temporary Alternate Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.1 When there is no alternate delegate credentialed by the 45-day credentialing deadline, an alternate delegate who was appropriately selected via the entity's rules may be credentialed as a temporary alternate delegate for that meeting only.

2.10.2.2 When there is no appropriately selected alternate delegate available, a member of the entity who is also an AMA member may be credentialed as a temporary alternate delegate, who shall be eligible to serve at that meeting only.

2.10.2.3 Temporary Medical Student Regional Alternate Delegate. The credentialing authority for the Medical Student Section may credential a member of the Medical Student Section who has a written endorsement from their constituent association and who is from the same Medical Student Region as the absent alternate delegate as a medical student regional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate. The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

The following chart provides a link to the Bylaws that provide more details about each entity represented in the HOD:

Represented Entity	**Relevant Bylaw**	**Selection Mode**
Constituent Association	2.1.2	Selected
National Medical Specialty Society	2.2.2	Selected
Medical Student Regional Delegates and Alternates Delegates	2.3.3	Elected. Bylaw 7.3.4.3 specifies the timing of the elections.
Resident and Fellow Sectional Delegates and Alternate Delegates	2.4.3	Elected. Bylaw 7.1.6.2 specifies the timing of the election.
AMA Sections (MSS, RFS, YPS, SPS, APS, OMSS, IMGS, UMAS, IPPS, WPS, PPPS, LGBTQ+ Section)	2.6	Election (with election method and mechanism for filling vacancies contained in the rules of each Section as approved by the Board of Trustees).
Federal Services	2.6	Selected
National Medical Association	2.6	Selected
American Medical Women's Association	2.6	Selected
American Osteopathic Association	2.6	Selected
Professional Interest Medical Association	2.6	Selected

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 04-A-26

Subject: Carceral Systems and Practices in Behavioral Health Emergency Care

Presented by: Rebecca Brendel, MD, Chair

Policy D-345.970(3), "Carceral Systems and Practices in Behavioral Health," was adopted at the 2025 AMA Annual Meeting, and directs the following:

> 3. Our AMA asks the Council on Ethical and Judicial Affairs to study this topic to provide clearer guidance for healthcare professionals regarding interactions with law enforcement while caring for patients and shackling of youth and adults in carceral custody, with particular attention to the removal of.

The medical care of persons in legal custody presents a range of complex ethical considerations for physicians and other health professionals. When caring for individuals in legal custody, physicians may face competing obligations arising from institutional circumstances such as security requirements or law enforcement involvement.

In response to the directive in D-345.970(3), the Council on Ethical and Judicial Affairs (CEJA) is studying these issues to determine whether additional guidance in the AMA *Code of Medical Ethics* is warranted. A forthcoming Council report will examine the ethical considerations associated with the treatment of persons in legal custody.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 06-A-26

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Rebecca Brendel, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

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APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2025 – MARCH 31, 2026

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
11	Determinations of no probable cause
12	Determinations following a plenary hearing
10	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
11	No sanction or other type of action
3	Monitoring
8	Probation
2	Revocation
0	Suspension
1	Denied
0	Suspension lifted
12	Censure

Physicians Reviewed	PROBATION/MONITORING STATUS
11	Members placed on Probation/Monitoring during reporting interval
8	Members placed on Probation without reporting to Data Bank
12	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
30	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
9	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-26

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Rebecca Brendel, MD, Chair

At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 01-I-25, "Amendment to Opinion 1.1.1 "Patient-Physician Relationships." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-1.1.1 – Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilities to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship commences when a physician begins to serve a patient's medical needs. The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times. (I, II, III, V, VI, VIII, IX)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 02-A-26

Subject: Research Involving Pregnant and Lactating Individuals

Presented by: Rebecca Brendel, MD, Chair

At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 03-I-25, "Ethical Impetus for Research in Pregnant and Lactating Individuals." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-7.3.4.1 Research Involving Pregnant and Lactating Individuals

Research involving pregnant and lactating individuals, including but not limited to, research regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses or nursing infants, must balance the health and safety of individuals who participate and the well-being of their fetuses or nursing infant against the desire to develop new and innovative therapies. Although it is important to carefully consider potential fetal risks involved when pregnant and lactating individuals participate in research, it is critical to realize that large scale exclusion from participation by these individuals has also precluded potential benefits and in some cases resulted in harm for this group. The paucity of data on safe and effective medical treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing between pursuing medical interventions with uncertain risks to themselves and their fetuses or nursing infants, or foregoing the interventions altogether, which might itself cause harm due to undertreatment of medical conditions.

Understanding both the potential risks of participation and of non-participation, physicians conducting research must obtain the informed, voluntary consent of pregnant or lactating individuals, and adhere to general principles for ethical conduct of research as in all human participant's research. In addition, physicians conducting research should:

(a) Include pregnant and lactating individuals in research for which they would otherwise be eligible in order to establish a greater knowledge base, produce relevant data, and promote respect for individuals.

(b) Consider excluding pregnant and lactating individuals only when a study poses a substantial risk of significant harm to them or their fetuses or nursing infants, and:

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i. specify why the research excludes pregnant and lactating individuals;

ii. seek alternative research methodologies to rectify gaps in knowledge.

(c) Where scientifically appropriate and available, base studies that include pregnant and lactating individuals on well-designed, ethically sound, existing research with nonhuman animals or nongravid human participants to better assess potential risks.

(d) Minimize risks to the fetus or nursing infant to the greatest extent possible, especially when the research is not conducted primarily to investigate potential benefit for fetuses or nursing infants, but rather for the development of important biomedical knowledge that cannot be obtained by any other means. (I, III, V)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Study of the Federal Employees Health Benefits Program (FEHBP)

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates adopted Policy D-185.906, which directs the American Medical Association (AMA) to conduct a thorough study of the Federal Employees Health Benefits Program (FEHBP) to understand its successes, failures, strengths and weaknesses, and compare it with AMA Policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform. This report, which is presented for information to the House of Delegates, discusses key features of the FEHBP, its role in health reform efforts, and relevant AMA policy.

The FEHBP provides health insurance coverage to more than eight million civilian federal workers, retirees, and their dependents (non-federal employees are ineligible) and is the largest employer-sponsored insurance program in the country. For decades, the FEHBP has been viewed by many as a highly successful program that offers robust health plan competition and choice. Other advantages include its comprehensive benefits package, generous federal contributions, and continuity of coverage into retirement. Limitations include the FEHBP's high and increasing costs as well as its limited eligibility.

Although various health reformers from across the political spectrum have pointed to the FEHBP as a model, health system reform proposals that are based on the FEHPB have diminished in recent years, perhaps due to the availability of exchange plan coverage under the Affordable Care Act and/or because the program is less competitive and more costly than it once was. 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. Of note, AMA Policy H-165.846 supports using the FEHBP as a standard for assessing meaningful coverage. The Council emphasizes that this is only one such standard, and that the principles and guidelines embedded throughout AMA policy form the basis by which the AMA will continue to evaluate an array of health reform approaches, including proposals that may build upon the FEHBP or incorporate some of its features. That said, we do not necessarily view the FEHBP as the most promising solution to achieving universal coverage, primarily due to the program's limited eligibility and rising costs. We also believe that allowing the public to access FEHBP coverage would severely disrupt the program's risk pool, which has been key to its success over the years. Because 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, we make no policy recommendations at this time.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-26

Subject: Study of the Federal Employees Health Benefits Program (FEHBP)

Presented by: Betty Chu, MD, MBA, Chair

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

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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] 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]

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 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]

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 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.

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.
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. (Modify Current HOD Policy)
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)

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)

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 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)