

## **Informational Reports (A-26)**

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- 05 Update on Corporate Relationships
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### **Report(s) of the Council on Ethical and Judicial Affairs**

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- 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

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

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

<b>Funding Institution</b>	<b>Project</b>	<b>Amount Received</b>
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	<u>9</u>
<b>Government Funding</b>		<b><u>2,356</u></b>
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	<u>20</u>
<b>Nonprofit Contributors</b>		<b><u>1,256</u></b>
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	<u>4</u>
<b>Other Contributors</b>		<b><u>54</u></b>
<b>Total Grants and Donations</b>		<b><u>\$ 3,666</u></b>

# REPORT OF THE BOARD OF TRUSTEES

BOT Report 05-A-26

Subject: Update on Corporate Relationships

Presented by: David H. Aizuss, MD, Chair

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1 PURPOSE

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

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

10  
11 BACKGROUND

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

18  
19 YEAR 2025 RESULTS

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

25  
26 CONCLUSION

27  
28 The Board of Trustees (BOT) periodically evaluates the CRT review process to balance risk  
29 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
66659	<b>ICD Healthcare Burnout Symposium</b> – 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	<b>AAPC HEALTHCON Events</b> - 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	<b>Medical Library Association Annual and Chapter Meetings</b> – 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	<b>American Society of Bioethics and Humanities Conference</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68242	<b>ViVE Sponsorships</b> – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	01/27/25
68282	<b>DeviceTalks Conference</b> – Sponsorship with VDL name and logo.	WTWH Media	01/31/25
68409	<b>Machine Learning for Healthcare Conference</b> – 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	<b>Becker’s Collaborations</b> - 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	<b>March of Dimes Gourmet Gala</b> - 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68548	<b>Credentialing State Shows</b> – 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	<b>AZARA User Conference</b> – Sponsorship with AMA MAP hypertension program name and logo.	Azara Healthcare Upstream USA	02/18/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68522	<b>AMA International Medical Graduates Section Annual Meeting Desserts Reception –</b> Repeat sponsorship with AMA name.	Educational Commission on Foreign Medical Graduates	02/24/25
68703	<b>HealthStream Thrive25 Annual Conference –</b> Sponsorship with AMA name and logo.	HealthStream Hardenbergh Group American Board of Medical Specialties Evergreen Health Partners Axuall	02/26/25
68713	<b>IAIABC Forum and Convention -</b> 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 HealthSystems 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68764	<b>Health Care Value Week Value-based Payment Summit -</b> 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	<b>National Medical Association Events-</b> 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68849	<b>Asian American Journalists Association's Annual Convention</b> – 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	<b>i2i Client Conference Sponsorship</b> – 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	<b>Chief Medical Officer Exchanges</b> – Repeat sponsorships with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Ambience Healthcare Microsoft SaVia Health Solventum Corporation	03/06/25
68863	<b>National Association of Hispanic Journalists Conference</b> - 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68886	<b>National Multiple Sclerosis Society's Dinner of Champions</b> – 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	<b>ACCME's Learn to Thrive Conference</b> – 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	<b>Ai4 Technology Conference</b> – Collaboration with AMA name and logo.	Ai4 Fora Group	03/22/25
69491	<b>AHCJ Conference</b> – 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	<b>Bryce Harlow Foundation 44th Annual Awards Dinner</b> – Repeat sponsorship with AMA name and logo.	Bryce Harlow Foundation American Express Microsoft Johnson & Johnson Korn Ferry International	03/31/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
69657	<b>Bernard Lown Awards Dinner</b> – Repeat sponsorship with AMA name and logo.	The Lown Institute Grimshaw-Gudewicz Foundation Robert Wood Johnson Foundation	04/07/25
70242	<b>TruBridge National Client Conference</b> – Repeat sponsorship with AMA name and logo.	TruBridge i2i Population Health Blockit Now Inc SureScripts Wolters Kluwer	04/10/25
70426	<b>Minority Health Institute’s Seventh Annual Summit</b> – 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	<b>Precision Health Information Network Summit</b> – Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina	04/24/25
69501	<b>American Conference on Physician Health</b> – Repeat sponsorship with AMA name and logo.	Stanford Medicine Mayo Clinic The Physician’s Foundation	05/01/25
70611	<b>NAMSS Annual Educational Conference and Exhibition</b> - 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
70260	<b>Rock Health Summit</b> – 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	<b>CFHA Integrated Care Conference</b> – 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	<b>IPPNW Congress</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
71073	<b>Institute of Medicine of Chicago Leadership Awards</b> – 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	<b>SAWCA Convention and Luncheon</b> – 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	<b>AAMC Annual Meeting</b> – 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	<b>Greenway ENGAGE Client Summit</b> – Repeat sponsorship with AMA name and logo.	Greenway Health HealthAsyst Phreesia Inc RevSpring Inc Rivet Health Solventum Corporation	06/23/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
71309	<b>WOEMA Conference</b> - 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	<b>NCOIL Chicago and Annual Meetings</b> – Sponsorships with AMA name and logo.	National Council of Insurance Legislators	07/07/25
71912	<b>Healthy Chicago Hypertension Awareness Day</b> – Collaboration with RTP name and logo.	Healthy Chicago Black Women’s Expo MGPG Events	07/24/25
72107	<b>The Systems Summit on Healthcare Transformation</b> – 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	<b>Vizient Connections Summit</b> – 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	<b>AthenaHealth Thrive Summit</b> – Sponsorship with AMA name and logo.	AthenaHealth Qure4u Software OhMD Software	08/28/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
72796	<b>Congressional Black Caucus Foundation Phoenix Awards Dinner</b> – Sponsorship with AMA name and logo.	Congressional Black Caucus Foundation	09/03/25
72324	<b>Association of American Indians Physicians 53rd Annual Meeting</b> – 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	<b>AGMB Conference</b> – Sponsorship with JAMA Network name and logo.	German Medical Library Association (AGMB) Elsevier Karger Publishers Frontiers Publishing Springer Nature EBSCO	09/03/25
73079	<b>HLTH Conference</b> - Repeat sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	09/17/25
73235	<b>MD-Staff Educational Conference Sponsorship</b> – Repeat sponsorship with AMA name and logo.	PreCheck ABMS Solutions The Greeley Company Hardenbergh Group	09/29/25
73773	<b>National Hispanic Health Foundation Scholarship Gala</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
73898	<b>South by Southwest MedTalk Conference</b> – 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	<b>AIMed Conference</b> – 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	<b>HealthLeaders Chief Executive Officer Exchange</b> – Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders	10/31/25
74455	<b>Anarcha, Lucy, Betsey Annual Conference</b> – Repeat sponsorship with AMA name and logo.	Faith Crusade Montgomery Rescue Mission Robert Wood Johnson Foundation Every Mother Counts	11/19/2025
74501	<b>STFM Conference on Medical Student Education</b> – Sponsorship with AMA name and logo.	Society of Teachers of Family Medicine	11/24/25
74808	<b>MIT AI Conference</b> – Sponsorship with AMA name and logo.	MIT Critical Data Lab MIT Industry Liaison Program	12/09/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
75147	<b>HIMSS Global Health Conference &amp; Exhibition</b> – 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**

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68850	<b>AHIMA Workshop</b> – Repeat training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	03/12/25
69161	<b>Noodle Nursing Scholar Program Collaboration</b> – Educational series on BP Measurement with AMA name and logo.	Noodle Corporation Noodle Nursing Scholar Program	03/12/25
70209	<b>HealthBegins Collaboration</b> – Collaboration for educational materials with AMA name and logo.	HealthBegins	04/10/25
71371	<b>IPPNW Webinar</b> – Educational webinar featuring Journal of Ethics name and logo.	International Physicians for the Prevention of Nuclear War	07/01/25
72560	<b>Transforming Lifelong Learning through Precision Education</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
73202	<b>Clinical Skills Workshop</b> – 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	<b>Credentialing School Sponsorship</b> - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Symplr Federation of State Medical Boards	11/06/25

**COLLABORATIONS/AFFILIATIONS**

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
66537	<b>Practice Transformation Survey Assessment</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
66537	<b>Practice Transformation Survey Assessment</b> – 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	<b>Medbiquitous Collaboration</b> – Collaboration on data standards development with AMA name and logo.	Medbiquitous Association of American Medical Colleges	01/23/25
68323	<b>Healthcare Professional Gun Violence Campaign</b> – Collaboration with AMA name and logo.	Ad Council	02/06/25
68550	<b>Prevention Strategy Collaboration with Health Care Organizations</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68516	<b>Agree-to-Agree Youth Gun Violence Prevention Campaign</b> – 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	<b>Target BP Promotional Video</b> – 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	<b>American Medical Group Association</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
68707	<b>American Telemedicine Association</b> – 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	<b>Abortion Defense Network</b> – 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	<b>All In Campaign</b> – 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
70613	<b>ACCME Journal of Graduate Medical Education</b> <b>“Reimagining Residency” Edition -</b> Collaboration with AMA name and logo.	Accreditation Council for Graduate Medical Education Journal of Graduate Medical Education	05/01/25
70551	<b>COVID-19 Monument of Honor, Remembrance, &amp; Resilience</b> – 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	<b>“A Guide to Collaborative Drug Therapy Management”</b> – Collaboration with AMA name and logo.	American College of Clinical Pharmacology	05/21/25
71006	<b>2025 Residency Guides</b> – Collaboration on medical resident guides with AMA name and logo.	Association of American Medical Colleges Organization of Program Directors Association	06/03/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
71657	<b>JAMA Network Worldwide</b> – Updated content agreement for online reference service with AMA name and logo.	USACO Corporation	07/17/25
71357	<b>The Naloxone Project</b> – Co-branded information brief for healthcare workers with AMA name and logo.	The Naloxone Project	07/21/25
71560	<b>Emergency Care for Pregnant Patients</b> – 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	<b>“Brother to Brother” Campaign and Maternal Health Roundtable</b> – Collaboration on heart and maternal health campaigns with RTP name and logo.	Association of Black Cardiologists	08/07/25
72679	<b>AMA Annual Research Challenge</b> – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	08/28/25
73018	<b>Mental Health Parity Collaboration</b> – 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	<b>“What Doctors Wish Patients Knew” series</b> – Cobranded articles with AMA name and logo.	HCA Healthcare	09/25/25

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
73526	<b>Health Care Payment Policy Insights Report</b> - Report with AMA name and logo.	Alliance for Health Policy	10/06/25
73993	<b>Elsevier Publishing</b> – Collaboration on textbook with AMA name and logo.	Elsevier	11/14/2025
74666	<b>Leadership Council for Healthier Communities</b> – 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	<b>iHeart Media</b> – Podcast series with AMA name and logo.	iHeartMedia iHeartPodcasts iHeart Ignite	12/04/25
74338	<b>Federation of State Physician Health Programs</b> – Repeat sponsorship with AMA name and logo.	Federation of State Physician Health Programs American Board of Medical Specialties Copic Insurance Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	12/06/25
75082	<b>The Health Management Academy</b> – Sponsorship with AMA name and logo.	The Health Management Academy	12/19/25

**MEMBER PROGRAMS**

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

**BUSINESS ARRANGEMENTS/LICENSING PROGRAMS**

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations/Organizations</u>	<u>Approval Date</u>
69233	<b>Official Disability Guidelines (ODG by MCG)</b> – 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	<b>QGenda</b> - Licensing agreement for AMA VeriCre product with AMA name and logo.	QGenda LLC	03/19/25
70183	<b>OpenEvidence</b> – JAMA Network content licensing agreement with JAMA Network name and logo.	Open Evidence Inc	04/25/25
71244	<b>Validic</b> – Content licensing agreement with AMA MAP hypertension name and logo.	Validic Inc	06/25/25
71405	<b>Cedaron</b> - AMA Guides to Permanent Impairment content licensing agreement with AMA Guides name and logo.	Cedaron	07/15/25
73591	<b>ResearchGate</b> - JAMA Network content licensing agreement with JAMA Network name and logo.	ResearchGate	10/14/25
74378	<b>Symplr</b> - 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

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

## 4 5 INTRODUCTION

6  
7 The American Medical Association (AMA) is the largest and most influential organization  
8 representing the voices of hundreds of thousands of physicians, residents, and medical students  
9 across the United States. The AMA advocates for policies that improve access to quality care,  
10 strengthen the patient-physician relationship, promote physician autonomy and wellbeing, advance  
11 science and technology, and uphold the high medical ethics of the profession. The AMA’s mission  
12 is to promote the art and science of medicine and the betterment of public health.

### 13 14 *Amplifying physician voices and shaping policy*

15  
16 In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C. and across the  
17 country to ensure that physician clinical experience and expertise guide the policy changes and  
18 technological advances that are critical to medicine’s future. At the national level, the AMA  
19 continued to push to reform the Medicare reimbursement system, fix prior authorization, promote  
20 physician-led care and more by:

- 21  
22 • Generating more than \$100 million in earned media and ad impressions and driving more  
23 than 600,000 physicians and patients to contact their legislators about Medicare payment  
24 reform through our FixMedicareNow grassroots campaign.
- 25 • Securing a commitment from America’s Health Insurance Plans (AHIP) and the Blue  
26 Cross Blue Shield Association to lessen the burden of prior authorization in 60 of their  
27 member plans.
- 28 • Opposing legislation that would expand pharmacists’ scope of practice with respect to  
29 testing and treating patients for influenza, COVID-19, RSV, and strep throat.

30  
31 In partnership with state and specialty societies, AMA advocacy protected patients by:

- 32  
33 • Blocking nearly 100 bills that would have inappropriately expanded the scope of practice  
34 for physician assistants, pharmacists, optometrists and more.
- 35 • Providing support and resources to help enact 22 prior authorization bills that sought to  
36 decrease reporting requirements, reduce delays in patient care, and improve transparency.
- 37 • Partnering with the Dr. Lorna Breen Heroes’ Foundation to verify that 40 state medical  
38 boards and more than 1,800 health systems (and others) removed stigmatizing mental  
39 health questions from their credentialing applications.

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

4  
5 The AMA was a critical voice for physicians on key legal issues, including the implementation of  
6 the No Surprises Act (*TMA v. HHS*), scope of practice challenges (*Palmer v. Bonta*), and e-  
7 cigarette regulation (*FDA v. R.J. Reynolds Vapor*), among other matters vital to physicians.

8  
9 The AMA continues to serve as a lead plaintiff in a major antitrust case against MultiPlan, a data  
10 analytics company accused of creating a price-fixing conspiracy with the largest commercial health  
11 insurance companies in the country. The AMA successfully opposed MultiPlan’s motion to dismiss  
12 the suit, and the case is proceeding with discovery.

13  
14 In a year of high-profile challenges to public health and public health institutions, physician  
15 leadership was more important than ever. The AMA provided steadfast leadership during  
16 uncertainty, defended science, and advocated for evidence — not politics — to guide care  
17 decisions and public health policy. We accomplished this by:

- 18  
19
- [Publicly challenging decisions](#) that would weaken recommendations and undermine public  
20 confidence in life-saving childhood vaccinations.
  - Reaffirming decades of scientific research that showed no link between vaccines and  
21 autism.
  - Releasing information graphics to clear up confusion around vaccine misinformation and  
22 facilitate honest conversations between physicians and patients.
- 23  
24  
25

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

30  
31 *Driving the future of medicine*

32  
33 The rapid growth of digital health and augmented intelligence (AI) accelerated in 2025, with more  
34 physicians and health systems experiencing their transformative potential. Going forward, it’s  
35 crucial for physicians to lead the way in shaping and implementing these technologies.

36  
37 With the launch of the [AMA Center for Digital Health and AI](#) in 2025, we are taking the lead in  
38 this space. The AMA’s new Center for Digital Health and AI was created to give physicians a  
39 platform to help establish ethical guardrails, shape policy and support workflow integration so that  
40 AI and other digital tools enhance care rather than complicate it. The new center is focusing on:

- 41
- Policy and regulatory leadership: Working with regulators, policymakers and technology  
42 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  
43 tools so they work within clinical workflows and enhance the patient and clinician  
44 experience.
  - Education and training: Equipping physicians and health systems with the knowledge and  
45 tools to integrate AI efficiently and effectively into practice.
  - Collaboration: Building partnerships across the tech, research, government and health care  
46 sectors to drive innovation aligned with patient needs.
- 47  
48  
49  
50

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

5  
6 AMA hosted the ChangeMedEd® 2025 conference in Chicago, attracting 600 attendees and  
7 featuring over 140 presentations, 120 posters, and 60 breakout sessions. Thirty “blue sky” AI ideas  
8 were presented, with three selected to receive \$20,000 AMA grants for further development. Post-  
9 conference surveys showed 97% of respondents viewed AMA as a leader in medical education  
10 innovation, and 93% plan to apply conference concepts in their work within the next year.

11  
12 The AMA reported outcomes from its six-year, \$20 million Reimagining Residency program,  
13 which significantly improved residency training. Highlights include system-wide adoption of  
14 interprofessional principles—leading to shorter stays, lower costs, and better patient satisfaction—  
15 new national OB/GYN residency selection standards, and better alignment of education and  
16 workforce needs in NC, CA, and OR. The program’s impact includes:

- 17
- 18 • 343 residency programs
- 19 • ~10,700 medical students
- 20 • ~10,400 residents/fellows
- 21 • ~2,400 faculty
- 22

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

- 26
- 27 • 4.6 million visitor sessions
- 28 • 750,000 courses completed
- 29

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

34  
35 VeriCre™ gained solid adoption with over 120 customers across 600 sites nationwide, streamlining  
36 credentialing and boosting efficiency. Its secure “physician wallet” lets physicians easily manage  
37 and share credentials via integration with third-party software.

38  
39 AMA launched the Value-Based Care Workgroup to enhance the role of Current Procedural  
40 Terminology (CPT®) in value-based care, reinforcing the code set’s long-term relevance and  
41 integrity. The Workgroup secured CPT Editorial Panel approval for updated care management code  
42 language—reflecting modern, physician-led, team-based care—for inclusion in the 2027 code set.

43  
44 The AMA enhanced its CPT Educational Content platform and launched CPT Refresh/Refresh  
45 Premium, creating a modern digital system to streamline coding and reduce physician burnout. The  
46 platform handled over 21 million API calls this year, a 20 percent increase in content production—  
47 delivering over 200 in-depth CPT educational resources to meet evolving healthcare needs.

48  
49 JAMA Network launched JAMA+ Women’s Health, a new digital resource designed to elevate the  
50 visibility and accessibility of trusted, peer-reviewed content that advances health care for women.

1 *Removing obstacles that interfere with patient care*

2  
3 Administrative barriers like prior authorization are just one challenge physicians face.  
4 Health disparities—such as food deserts and unsafe housing—can affect patient health as  
5 significantly as clinical care.

6  
7 The AMA launched its first [Community Health Impact Lab](#) micro grants in 2025 to invest in  
8 physicians who have ideas to address barriers they see in their communities with local, creative and  
9 measurable solutions.

- 10  
11
  - 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  
12 outcomes among patient populations who often face obstacles to healthy living in their  
13 communities.

14

15  
16 This initiative empowers physicians to address community health challenges and drive change,  
17 backed by AMA support. Micro grant recipients will be notified in April 2026 and have 12 months  
18 to implement their ideas, with guidance from the AMA throughout.

19  
20 The AMA Joy in Medicine® Health System Recognition Program received a record number of  
21 applications in 2025 and honored its largest group of organizations to date (109) bringing the total  
22 recognized cohort to 164. This represents a 76 percent increase over 2024.

23  
24 The AMA’s Organizational Biopsy® team partnered with 151 health care organizations—a 32  
25 percent year-over-year increase—to conduct well-being assessments. This growth was supported  
26 by the development of innovative tools, such as the Organizational Biopsy Assessment and  
27 Resource Calculator, which supported data-driven decisions. These scalable tools also established  
28 repeatable usability testing frameworks for other AMA digital products.

29  
30 The 5<sup>th</sup> American Conference on Physician Health™, co-sponsored with Mayo Clinic and Stanford  
31 Medicine, achieved record attendance and presented the highest number of abstracts to date.

32  
33 AMA STEPS Forward® enhanced its content library and achieved substantial growth in  
34 engagement, with webinar attendance increasing by 180 percent year-over-year and podcast  
35 downloads rising by 13 percent year-over-year.

36  
37 The AMA, in partnership with The Kennedy Forum, introduced the Mental Health Parity Index—a  
38 transformative tool that measures market-level violations of mental health parity laws by  
39 commercial health plans, helping state and federal regulators strengthen enforcement.

40  
41 *Leading the charge to improve health outcomes*

42  
43 With firearm injuries now the leading cause of death among U.S. children and teens, the AMA’s  
44 Firearm Injury Prevention Task Force, the Ad Council, and health care leaders launched a digital  
45 resource hub to support clinicians in firearm injury prevention conversations. The launch generated  
46 20 media articles, over 60,000 press release engagements, 51 partner social posts, and 8.5 million  
47 potential impressions across media and social channels.

48  
49 The AMA created the Center for Optimal Health Outcomes (COHO), merging the areas of  
50 Improving Health Outcomes and the Center for Health Equity. COHO’s work will be focused  
51 externally, centered on these interconnected pillars:

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

5

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

9

10 To support the Million Hearts campaign, the AMA partnered with the Centers for Disease Control  
11 and Prevention (CDC) and Alliance Chicago, engaging 5 Health Center Controlled Networks and  
12 19 community health centers to prevent heart attacks and strokes in over 900,000 adults—focusing  
13 on minority, rural, and medically underserved communities.

14

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

19

#### 20 *Membership*

21

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

26

#### 27 *EVP Compensation*

28

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

34

35 Dr. Madara remained on the payroll through December 2025 to provide transition support. Total  
36 compensation during this period was \$476,499 in salary, reduced by \$1,564 in pre-tax deductions.  
37 Other taxable amounts per the contract were: \$24,102 in imputed earnings for life insurance,  
38 \$1,350 paid for parking and \$1,100 for health club dues.

39

40 During 2025, pursuant to his employment agreement, total cash compensation paid to John J.  
41 Whyte, MD included \$787,500 in salary and a \$150,000 sign-on bonus, reduced by \$6,204 in pre-  
42 tax deductions. Other taxable amounts per the contract were as follows: \$2,860 imputed earnings  
43 for life insurance, \$525 for a cell phone stipend, \$1,820 paid for parking. \$1,458 paid for health  
44 club dues and \$11,686 for travel expenses to and from the Chicago office. Dr. Whyte's  
45 employment began on June 1, 2025.

46

47 For additional information about AMA activities and accomplishments, please see the "AMA 2025  
48 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

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1 This report summarizes trends and news on tobacco usage, policies, and tobacco control  
2 advocacy activities from March 2025 through February 2026. The report is written pursuant to  
3 American Medical Association (AMA) Policy D-490.983, “Annual Tobacco Report.”  
4

## 5 TOBACCO USE AT A GLANCE 6

7 The United States has continued to see decreases in tobacco use. Adult tobacco use dropped from  
8 19.3 percent in 2022 to 16.4 percent in 2023.<sup>1</sup> Furthermore, current tobacco use among middle  
9 and high schoolers dropped from 10 percent in 2023 to 8.1 percent in 2024.<sup>2</sup> However, tobacco  
10 product use remains the leading cause of preventable disease and death in the United States.<sup>3</sup>  
11 There is limited availability of detailed information about tobacco trends in the last year because:  
12 (1) 2025 National Youth Tobacco Survey (NYTS) data collection was suspended midstream with  
13 the dismantling of the Office of Smoking and Health (OSH) and (2) there are few published  
14 analyses of 2025 National Health Interview Survey (NHIS) data.<sup>4</sup>  
15

16 According to the 2024 Behavioral Risk Factor Surveillance System (BRFSS), 11percent of adults  
17 report current smoking, with the highest rates among Indian and Alaskan Native individuals (22  
18 percent) and the lowest rates among Hawaiian/Pacific Islanders and Hispanic individuals (5  
19 percent and 10 percent respectively).<sup>5</sup> Recent data from the Monitoring the Future study shows  
20 that in 2025, past 30-day nicotine use (e.g., cigars, cigarettes, hookah, vaping, nicotine pouches,  
21 smokeless tobacco) among 12<sup>th</sup> graders increased from 17 percent in 2024 to 22 percent in  
22 2025—though little change occurred among 8<sup>th</sup> and 10<sup>th</sup> graders. This reflected small, cumulative  
23 increases across multiple tobacco products rather than a dominant change in any single drug. In  
24 2025, lifetime use of nicotine pouches increased in all grades and vaping nicotine in the past 30  
25 days increased in 10<sup>th</sup> and 12<sup>th</sup> grades.<sup>6</sup>  
26

### 27 *Adult Tobacco Use* 28

29 In 2022, NHIS found that cigarettes were the most commonly used tobacco product among  
30 adults, followed by electronic cigarettes (e-cigarettes), cigars, smokeless tobacco, and pipes.<sup>7</sup> E-  
31 cigarettes were the second most commonly used tobacco product among U.S. adults.<sup>8</sup> E-cigarette  
32 use is increasing amongst adults, with 4.5 percent of adults using e-cigarettes in 2019 and 6.5  
33 percent in 2023.<sup>9</sup> Among adults who smoke e-cigarettes, younger adults are more likely to report  
34 having never smoked cigarettes.<sup>10</sup> In 2022, 66% of adults aged 18-24 reported never smoking

1 cigarettes, compared to 21.6% of adults aged 25-44 years and 11.3% of adults aged 45-64  
2 years.<sup>11</sup>

### 3 4 *Youth Tobacco Use*

5  
6 E-cigarettes are the most used tobacco product among youth in the United States.<sup>12</sup> In 2024, 5.9  
7 percent(1.63 million) of middle and high school students reported currently using e-cigarettes.<sup>13</sup>  
8 This was a decrease from 7.7 percent in 2023.<sup>14</sup> Among students who reported currently using e-  
9 cigarettes, 87.6 percent used flavored e-cigarettes, 38.4 percent used an e-cigarette on at least 20  
10 of the last 30 days, and 26.3 percent used an e-cigarette every day.<sup>15</sup> E-cigarettes remained the  
11 most used tobacco product among kids, and nicotine pouches were the second most used tobacco  
12 product.<sup>16</sup> Separate data from the CDC Foundation found that nicotine pouch use among youth  
13 ages 13-20 increased by nearly fourfold from 2022 to 2025.<sup>17</sup>

### 14 15 *Effects of Tobacco Use*

16  
17 Smoking combustible tobacco products can cause many diseases, including cancer,  
18 cardiovascular disease, and lung disease.<sup>18</sup> Cigarette smoking kills more than 480,000 Americans  
19 each year.<sup>19</sup> Cigarette smoking costs the United States more than \$600 billion in 2018, including  
20 more than \$240 billion in healthcare spending and nearly \$372 billion in lost productivity.<sup>20</sup>  
21 Similarly, smokeless tobacco puts users at risk for cancers of the mouth, esophagus, and  
22 pancreas.<sup>21</sup> Regardless of whether a tobacco product is combustible, use of tobacco products can  
23 expose users to toxic substances and lead to nicotine addiction.<sup>22</sup>

### 24 25 NOTABLE FEDERAL ADMINISTRATIVE ACTIONS

26  
27 The Centers for Disease Control and Prevention (CDC)'s Office on Smoking and Health (OSH)  
28 was the federal government's primary mechanism for meeting its obligations to prevent and  
29 reduce tobacco by educating the public about the dangers of smoking and tobacco use.<sup>23</sup> On  
30 April 1, 2025, nearly all OSH staff and contractors were terminated.<sup>24</sup>

31  
32 The OSH was also responsible for the *Tips from Former Smokers* media campaign, which was  
33 also terminated.<sup>25</sup> The *Tips* campaign featured real people from diverse backgrounds living with  
34 serious long-term health effects from smoking and secondhand smoke exposure.<sup>26</sup> From 2012-  
35 2018, the *Tips* campaign helped approximately one million people successfully quit smoking,  
36 prevented an estimated 129,000 early deaths, and contributed to \$7.3 billion in savings  
37 on smoke-related healthcare costs.<sup>27</sup> The termination of the campaign left at least \$65 million in  
38 congressionally directed tobacco prevention and cessation funding unused in 2025.<sup>28</sup>

39  
40 On April 1, 2025, a significant number of staff at the U.S. Food and Drug Administration  
41 (FDA)'s Center for Tobacco Products (CTP) were terminated or otherwise removed.<sup>29</sup> The CTP  
42 oversees the implementation of the Family Smoking Prevention and Tobacco Control Act and is  
43 entirely funded by tobacco industry user fees.<sup>30,31</sup> Some of CTP's responsibilities include setting  
44 performance standards, reviewing premarket applications for new and modified risk tobacco  
45 products, requiring new warning labels, and establishing and enforcing advertising and  
46 promotion restrictions.<sup>32</sup> While some staff have been rehired, the restructuring has reduced the

1 Center's capacity to enforce tobacco restrictions and thoroughly review tobacco product  
2 applications.<sup>33,34</sup> Furthermore, several actions from the Center for Tobacco Products actions will  
3 facilitate easier access to tobacco and nicotine products in the U.S. including: (1) authorizing the  
4 sale of 20 different Zyn products, (2) setting up a fast-track review process for premarket tobacco  
5 applications for nicotine pouches and (3) authorizing additional menthol flavored e-cigarettes for  
6 sale.<sup>35</sup>

7  
8 Millions of dollars in federal grants from the CDC to state and local health departments were  
9 delayed in 2025.<sup>36</sup> The CDC typically directs the money it receives from Congress to state and  
10 local health departments.<sup>37</sup> With the start of the new administration, the White House began to  
11 apportion money to CDC on a month-by-month basis.<sup>38</sup> As a result, funds for state programs to  
12 prevent and reduce tobacco use were delayed by months.<sup>39</sup> The delay caused extensive changes  
13 to several state tobacco control programs, including reductions in quitline or phone counseling  
14 services for tobacco users.<sup>40</sup>

## 15 16 EFFORTS TO ADDRESS TOBACCO CONTROL

### 17 18 *Changes to State Cigarette Taxes*

19  
20 In 2025, Indiana increased its cigarette tax by \$2.00 per pack, bringing its state cigarette tax to  
21 \$2.995.<sup>41</sup> Maine increased its cigarette tax by \$1.50 per pack, bringing its state cigarette tax to  
22 \$3.50 per pack.<sup>42</sup> Hawaii and New Jersey also passed small increases to their state cigarette  
23 taxes.

24  
25 On the other hand, Alabama passed a reduction in its tax on heated tobacco products.<sup>43</sup> This is a  
26 policy that has been pushed by Phillip Morris International (PMI) as its *IQOS* heated tobacco  
27 products re-enter the U.S. market.<sup>44</sup> Heated tobacco products heat tobacco sticks, rather than  
28 ignite it.<sup>45</sup> According to PMI, the produced aerosol is a healthier alternative to smoking.<sup>46</sup> While  
29 heated tobacco products generally emit lower levels of harmful ingredients than regular  
30 cigarettes, there is limited research on their short- and long-term health effects.<sup>47</sup>

### 31 32 *Funding for State Tobacco Prevention and Cessation Programs*

33  
34 Tobacco prevention and cessation programs are highly cost-effective.<sup>48</sup> For example, California's  
35 long-running tobacco control program has saved the state an estimated \$155 in healthcare costs  
36 for every \$1 invested.<sup>49</sup> Additionally, state tobacco prevention and cessation programs allow  
37 resources to be targeted to alleviate disparities in tobacco use and outcomes.<sup>50</sup> In fiscal year  
38 2026, 12 states have registered funding increases of nearly \$1 million or more.<sup>51</sup>

## 39 40 AMA LITIGATION CENTER

41 The AMA Litigation Center continues to be active in state and federal courts around the country  
42 in matters involving tobacco control and regulation of flavored electronic nicotine delivery  
43 systems (ENDS). In April 2025, the United States Supreme Court issued a favorable decision  
44 in *FDA v. Wages and White Lion Investments*, which reversed a Fifth U.S. Circuit Court of  
45 Appeals ruling in favor of ENDS manufacturers and sellers. If the Court upheld the lower court

1 ruling, companies could have marketed products that were clearly designed to appeal to children,  
2 with names such as “Jimmy the Juice Man Peachy Strawberry”, “Suicide Bunny Mother’s Milk  
3 and Cookies”, “Pink Lemonade”, “Iced Pineapple Express” and “Killer Kustard Blueberry.” The  
4 FDA had denied the companies’ applications for premarket approval of the tobacco products.  
5 The companies challenged the agency’s decision, arguing that the FDA did not give them fair  
6 notice about the evidentiary and comparative requirements used during the application stage and  
7 that the agency had changed its position on scientific evidence. The AMA joined several  
8 Federation members and anti-smoking partners in a [brief](#) explaining the harm caused by these  
9 products. The brief urged the court to conclude that the FDA was correct in how it determined  
10 that the companies should not be able to market the flavored e-cigarette liquids. The Supreme  
11 Court ruled that the FDA did not act in an arbitrary and capricious manner when it denied the  
12 companies’ applications and remanded the case to the Fifth Circuit to review other legal  
13 arguments.  
14

15 The AMA continues to join amicus briefs supporting the FDA's efforts to regulate the marketing  
16 and sale of flavored products. In January 2026, the AMA joined several Federation members and  
17 anti-smoking organizations in a [brief](#) to the Sixth Circuit on *Breeze Smoke LLC v. FDA*. Under  
18 the Family Smoking Prevention and Tobacco Control Act, the FDA must approve marketing  
19 plans before companies can go forward with them. The companies must demonstrate, among  
20 other things, that marketing the product would be “appropriate for the protection of public  
21 health”. The FDA denied flavored e-cigarette makers their request to market certain products.  
22 E-cigarette companies sought review of the FDA’s decision, claiming the administration did not  
23 consider certain evidence they submitted about the products’ potential public health benefits,  
24 such as reduced harm compared to smoking and marketing plans to curb youth uptake of vaping.  
25 They also claim, among other things, that the FDA essentially put a ban on marketing these  
26 products without a formal rulemaking process. In the brief, the AMA and others said the FDA  
27 followed the law and that the decision to not allow the marketing to move forward was the right  
28 one for public health.  
29

30 Additionally, the AMA has filed briefs supporting state and local regulation of flavored tobacco  
31 products and will continue to look for ways to support tobacco control in the courts.  
32

### 33 AMA ADVOCACY 34

35 In June 2025, the AMA sent a [letter](#) to the White House Office of National Drug Control Policy  
36 (ONDCP) to comment on the areas under consideration for the Administration’s 2026 drug  
37 policy priorities. The AMA expressed that it shares the Administration's goal to prevent the  
38 initiation of drug use before it starts—particularly among youth and adolescents. The AMA  
39 advocated for increased study of why youth and adolescent use of some illicit substances, such as  
40 tobacco, may be decreasing so that we can better understand and build on those best practices.  
41 The AMA also urged ONDCP’s help to support and/or identify opportunities to not only increase  
42 access to effective treatment for nicotine and other substance use, but also to support efforts to  
43 increase access to comprehensive mental health care, behavioral health counseling and  
44 medications that suppress cravings and withdrawal symptoms.  
45

1 In July 2025, the AMA sent a [letter](#) to the Massachusetts legislature in support of House Bill  
 2 2562 and Senate Bill 1568, which would prohibit the sale of tobacco products to individuals born  
 3 on or after January 1, 2006.

4  
 5 In August 2025, several AMA staff participated in the National Conference on Tobacco or Health  
 6 (NCOTH) in Chicago. This included speaking in a panel presentation on “The Impact of the  
 7 Public Health Community on Tobacco Litigation” by Lenoard Nelson.

8  
 9 In October 2025, the AMA signed onto a [letter](#) to the Food and Drug Administration commenting  
 10 on the Proposed Rulemaking on a Tobacco Product Standard for Nicotine Yield of Cigarettes and  
 11 Certain Other Combusted Tobacco Products, urging the agency to finalize a comprehensive rule  
 12 that will reduce nicotine levels in combustible tobacco products.

13  
 14 Also in October 2025, the AMA signed onto a [letter](#) to the chief appropriators in Congress urging  
 15 them to reject proposals to dramatically cut funding for tobacco prevention programs carried out  
 16 by the CDC and to maintain adequate funding for such programs instead. On February 3, 2026,  
 17 Congress enacted the Consolidated Appropriations Act, 2026, which provided level funding for  
 18 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.

# 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

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## 1 BACKGROUND

2  
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4 American Medical Association (AMA) to “develop an organizational unit, e.g., a Center or its equivalent,  
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13 in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy [H-65.946](#)  
14 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and  
15 inclusion strategy.” Towards the end of 2025, the AMA made the decision to rebrand and reframe its  
16 work in the pursuit of improving health outcomes; merging the Center for Health Equity and the  
17 Improving Health Outcomes (IHO) business unit into the Center for Optimal Health Outcomes (COHO)  
18 with the goal of building on the momentum established by the Center for Health Equity to engage  
19 communities in addressing health disparities and leveraging IHO staff’s clinical expertise, health system  
20 engagement, and community health organization partnerships. This report marks the seventh AMA  
21 Optimal Health Outcomes Annual Report.

## 22 23 DISCUSSION

24  
25 Our AMA has committed to advancing health outcomes and embedding equity across the organization  
26 and beyond. In 2025, the Center continued to collect enterprise-wide equity related work and track  
27 progress across all the AMA’s Business Units (BU). This report outlines the activities conducted by our  
28 AMA during calendar year 2025, divided into the four COHO pillars, demonstrating relevance, impact,  
29 and thought leadership: (1) Community Health Impact, (2) Health Systems Engagement, (3) Policy  
30 Development and (4) Data and Research.

### 31 Community Health Impact

32 The following are some of the relevant accomplishments toward community health impact during 2025:

- 33 • At the 2025 Annual and Interim HOD meetings, several reports, resolutions, and education  
34 sessions were presented, including the Council on Ethical and Judicial Affairs report: “[Laying the  
35 First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ  
36 Procurement and Transplantation](#).” The Council on Science and Public Health presented various  
37 reports on topics such as: [Addressing Social Determinants of Health Through Closed Loop](#)  
38  
39

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

- 9 • The AMA launched the [Community Health Impact Lab](#) micro grants that will award a total of \$1  
 10 million to support 20 physician-led initiatives aimed at improving health outcomes in their  
 11 communities. The grants will help physicians make a difference at the local level on critical  
 12 issues like food insecurity, caregiver support, maternal health and much more. The awardees will  
 13 be announced in 2026.
- 14 • The AMA committed an additional \$3 million multi-year investment as a West Side United  
 15 Anchor Mission Partner, contributing to a combined \$177 million financial mobilization for  
 16 projects on Chicago’s west side, including housing, loans, local purchasing, and job creation and  
 17 provided \$250,000 in direct support to West Side United to strengthen engagement and  
 18 programming capacities.
- 19 • In its sixth year, the AMA continued to promote the annual [Ad Council’s flu vaccination national](#)  
 20 [media campaign](#) with new English/Spanish public service advertisements (PSAs) encouraging  
 21 people to get vaccinated against seasonal flu to protect themselves and their community.
- 22 • The AMA conducted 44 burnout assessments at federally qualified health centers (FQHCs)  
 23 and/or community health centers, all organizations serving patients from predominantly and  
 24 historically underserved communities. Several participating FQHCs were recognized through the  
 25 AMA’s [Joy in Medicine® Health System Recognition Program](#). In addition, AMA staff had the  
 26 opportunity to shadow professionals at an FQHC located in Chicago’s south side (Alivio Medical  
 27 Center) and met with its leadership team to learn more about community needs and challenges.  
 28 Lessons learned by staff were used to inform and expand the reach and impact of the AMA’s  
 29 work.
- 30 • The AMA, in collaboration with The Kennedy Forum and Third Horizon, launched a new open-  
 31 access visual interactive mapping tool, the [Mental Health Parity Index](#) (MHPI). The tool allows  
 32 physicians, patients, policymakers, and other stakeholders to assess how well commercial  
 33 insurance plans are performing with regard to mental health parity laws. Specifically, this new  
 34 tool analyzes commercial insurance plans based on access, coverage and payment for mental  
 35 health and substance-use services as compared with physical health services using data published  
 36 by individual insurance plans. The tool was piloted in Illinois, and the aim is to expand  
 37 nationally.
- 38 • The AMA and the Ad Council, in collaboration with a coalition of health care leaders, launched a  
 39 new digital injury prevention resource hub at [Agree To Agree](#) to empower physicians and other  
 40 health care professionals to confidently engage patients in conversations related to firearm injury  
 41 prevention. The digital resource hub features the national [Agree to Agree](#) campaign’s videos, fact  
 42 sheets, toolkits and conversation guides for clinicians to help patients and their families  
 43 understand the risks associated with unsecured firearms and best practices for secure storage to  
 44 help reduce firearm related injuries and deaths.
- 45 • The AMA launched a structured private practice incubator program to support a select group of  
 46 physicians through the process of starting their own practice called the [Independent Practice](#)  
 47 [Incubator](#) (IPI). The IPI was launched as a pilot program to test the market and to be available for  
 48 physicians who might lack financial resources to engage with consultants or other external  
 49 partners. As part of the application, the participants were asked if there were any special

1 populations that they were interested in serving upon the opening of their practices; a number of  
 2 those in the program look to start their own practices to focus on underserved communities.

- 3 • AMA [STEPS Forward®](#) continued to hold events, reaching a wider audience of attendees, while  
 4 maintaining discounted attendance for FQHCs and safety-net providers. The bootcamps offer  
 5 evidence-based time management and team-based care strategies to provide quality patient care.  
 6 In 2025, an updated STEPS Forward resource page was created to specifically guide and support  
 7 FQHCs and safety-net providers on the AMA site.
- 8 • New STEPS Forward® content helped address determinants of health and differences in health  
 9 outcomes. For example, 2025 STEPS Forward® podcast content included nine optimal health  
 10 outcomes-related episodes, including (1) [Screening for Prediabetes: Pearl of the Month](#), (2) [How  
 11 to Take a Patient-Centered Approach to Cancer Care](#), (3) [Help for Patients with Uncontrolled  
 12 Hypertension: Pearl of the Month](#), (4) [One Federally Qualified Health Center's Journey to Joy in  
 13 Medicine](#) and (5) [A Lifeline for Moms: Providing Whole Person Care in Maternal Health  
 14 Settings](#).
- 15 • In 2025, the AMA content on optimal health outcomes experienced a 50 percent increase in  
 16 engagement from 2024, reaching three million website users. The AMA completed 16 website  
 17 accessibility improvements across its websites. As part of the AMA's efforts to complement and  
 18 enhance physician professional development, the AMA launched the AMA [Physician Education  
 19 Program](#) (PEP) to provide a flexible and robust continued learning experience specifically curated  
 20 for physicians. Topics covered range from optimizing health outcomes, quality and safety, well-  
 21 being, leadership development and more.
- 22 • On the AMA [Ed Hub™](#) site, the AMA published 128 new optimal health outcomes-related  
 23 activities and renewed 101, with user engagements reaching over 300,000. Notably, the AMA, in  
 24 partnership with the [Docs with Disabilities Initiative](#), completed filming for a nine-part webinar  
 25 series titled *Caring for People with Disabilities* with publication on the AMA Ed Hub™ planned  
 26 for 2026. Additionally, the AMA hosted the new podcast episode [Microplastics Infiltrate Our  
 27 Bodies: How Can Physicians Help?](#) which explores the impact of microplastics on public health  
 28 and reducing practice exposure to microplastics.
- 29 • Our AMA continued to follow the Enterprise Social Responsibility (ESR) team's community  
 30 engagement framework to build meaningful relationships with local organizations. In 2025, the  
 31 ESR team hosted 51 community engagement events across 16 community organizations,  
 32 including [Erie Neighborhood House](#), [Gardeners](#), [MyBlock MyHood MyCity](#), [Nourishing Hope](#),  
 33 [Imagine Englewood if](#), [Pilsen Food Pantry](#) and [Cardz for Kidz](#). This year two new community  
 34 partnerships were established with [Growing Home](#) and [Project Linus](#) to support their work to  
 35 address the social determinants of health and move toward community health impact.
- 36 • The AMA offered internships and fellowships to various groups. As an example, AMA IT hosted  
 37 29 Chicago Public School high school student interns from historically underrepresented  
 38 backgrounds and provided students with the opportunity to visit the AMA, engage with AMA IT  
 39 professionals and learn about the AMA's history and its role in promoting national health and  
 40 well-being. Additionally, the JAMA Network manuscript editing teams offered a summer  
 41 medical editing internship designed for third- and fourth-year college students to gain exposure to  
 42 medical editing and publishing as a career. The JAMA Editorial Fellowship Program also  
 43 welcomed ten early career academic physicians and nurses in the fully remote fellowship  
 44 program, intended to engage around editorial decision-making and enhance scientific  
 45 communication skills. Lastly, the AMA continued the Summer Health Law Internship for a rising  
 46 third-year law student, with a focus on differences in health outcomes and law.
- 47 • The AMA's [Release the Pressure](#) (RTP) campaign focused on addressing and improving heart  
 48 health among those with the highest burden of hypertension by encouraging them to prioritize  
 49 their blood pressure. The AMA Foundation, the Minority Health Institute, the National Medical  
 50 Association (NMA), the American Heart Association (AHA), and the Association of Black

1 Cardiologists (ABC) were engaged through RTP. RTP had a presence at conferences and  
2 conventions, including the NMA Colloquium on African American Health and the Congressional  
3 Black Caucus Foundation's 54<sup>th</sup> Annual Legislative Conference, engaging over 113 physicians.  
4

5 Updates on the AMA's diversity and inclusion strategy included a number of efforts and initiatives:  
6

- 7 • Internally, our AMA supports initiatives to enhance employee experience, engagement and well-  
8 being, anchored in four strategic areas: (1) Foundational Infrastructure, (2) Access and Fairness,  
9 (3) Skills-Based Learning and (4) Inclusive Culture and Climate. In 2025, the AMA consulted an  
10 external vendor to conduct the 2025 Employee Engagement Survey to provide current insights  
11 into employee experience, including critical engagement index metrics. Results will guide  
12 strategies to improve inclusion outcomes.
- 13 • The AMA continues to foster inclusion and belonging across the organization through nine  
14 Employee Resource Groups (ERGs) that organize intersectional programming designed to  
15 advance inclusive learning, cultivate community, and support personal and professional  
16 development of members through the following events: book clubs, volunteering, panels, and  
17 professional development workshops. All ERGs are open to all employees.
- 18 • Staff continued to surpass their individual, voluntary learning goals, averaging more than 20  
19 hours of flexible learning across related health topics in 2025. Within BUs, staff have led  
20 educational activities and events to strengthen community engagement and improve community  
21 health outcomes. For example, the AMA's Education Center held monthly learning sessions  
22 focused on optimal health outcomes and inclusion, offering over 15 hours toward individual  
23 learning goals. Additionally, the AMA's Health Solutions unit engaged in bias and engagement  
24 training which focused on employee inclusion. As part of this training, all staff completed a self-  
25 paced 90-minute course titled Breaking Bias Foundations from [Be More with Anu](#). Furthermore,  
26 19 AMA staff members also completed the three day in-person BRAVE leadership training that  
27 centers a trauma-responsive approach for leaders to enhance inclusion and retention of staff.  
28

### 29 Health Systems Engagement

30 The following are some of the relevant accomplishments toward health systems engagement during 2025:  
31

- 32 • The AMA and the American Heart Association (AHA) recognized nearly 2,400 organizations  
33 that committed to improving blood pressure control rates by submitting data to the 2025 Target:  
34 BP Achievement Awards. Over 38 million patients were served by 2,393 total eligible  
35 participating health care organizations across 49 U.S. states and territories.
- 36 • To advance improvements in maternal health, the AMA developed four new tools and resources  
37 to help health care organizations and clinical care teams improve blood pressure monitoring and  
38 management during pregnancy and postpartum period, including two AMA MAP HTN<sup>TM</sup>  
39 educational resources for [patients](#) and [clinical teams](#).
- 40 • To advance the national Million Hearts campaign, the AMA, in partnership with the CDC and  
41 Alliance Chicago, engaged five Health Center Controlled Networks and 19 community health  
42 centers with an aim to prevent heart attacks and strokes in over 900,000 adult patients, with a  
43 focus on minority, rural and medically under-resourced communities.
- 44 • Over 100 health care organizations used AMA solutions to help their physicians and care teams  
45 improve cardiovascular disease in patients. Through this collaboration, more than 4.1 million  
46 patients with hypertension were reached and over 2.3 million patients with hypertension were  
47 impacted to achieve improved blood pressure control; 39 percent of which, where data was  
48 available, were from historically underserved communities.
- 49 • In 2025, the AMA launched the new two-year [AMA Transforming Lifelong Learning Through  
50 Precision Education](#) portfolio to accelerate seamless lifelong learning and advance educational

1 equity. As part of the portfolio, the AMA will award a total of \$12 million in education grant  
 2 funding to a total of 11 selected grant teams, each receiving \$1.1 million over four years.  
 3 Grantees represent more than 80 institutions, including medical schools, residency programs,  
 4 health systems, and specialty societies across the country. The selected grant teams will join the  
 5 ChangeMedEd Consortium, which focuses on advancing precision medical education.

- 6 • The AMA published playbooks and other educational resources for physicians, practices and  
 7 health systems, such as one of the AMA STEPS Forward® toolkits [https://edhub.ama-  
 9 assn.org/steps-forward/module/2830076](https://edhub.ama-<br/>
    8 assn.org/steps-forward/module/2830076) focused on quality improvement goals for practices. This  
 10 STEPS Forward for Smaller Practices [toolkit](#) offers guidance on how a practice can better  
 11 understand its patient population and community by examining population data, as well as  
 12 intersectionality of identities.
- 13 • In 2025, the AMA hosted its sixth episode of the [National Health Equity Grand Rounds webinar  
 14 series](#), *Creating Conditions Vital to Health: Health Care's Role in Economic Progress*, at Rush  
 15 Medical Center's Rubschlager Building in Chicago. Health care leaders discussed how health  
 16 systems can invest in their communities to address vital conditions and improve health outcomes  
 17 for all. This event engaged 19 health care organizations, and a total of 362 physicians joined the  
 18 conversation.
- 19 • Three new collaborators joined the AMA's Ed Hub™ in 2025, including the Institute for  
 20 Exceptional Care, Cleveland Clinic Center for Continuing Education and University of  
 21 Washington. These organizations will be contributing to equity-focused content on the AMA Ed  
 22 Hub™ site and expand AMA high-impact learning.
- 23 • The AMA's 2025 media sponsorships focused on reaching diverse audiences, supporting events  
 24 with the National Association of Hispanic Journalists and the Asian American Journalists  
 25 Association.
- 26 • In 2025, the AMA concluded the first cohort of the [Equitable Professional Societies Learning  
 27 Network](#) aimed to help 17 state and specialty societies gain the knowledge, skills, resources and  
 28 tools to operationalize structural changes for optimal health outcomes.
- 29 • The [third cohort of the Medical Justice in Advocacy Fellowship](#), an educational initiative in  
 30 collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute,  
 31 culminated at the 2025 Interim meeting of the House of Delegates, where 10 physician leaders  
 32 were celebrated and presented their optimal health outcomes project concepts. The fourth cohort  
 33 of the Medical Justice in Advocacy Fellowship will begin in 2026.
- 34 • AMA staff continued to be present throughout 2025 at underrepresented physician convenings to  
 35 grow and foster relationships, as well as learn about health care priorities of these groups. Staff  
 36 participated in various conferences to support building alliances, learning about the context  
 37 necessary for restorative practice and incorporating context into the AMA's own work. These  
 38 conferences included: [National Hispanic Medical Association 28<sup>th</sup> Annual Conference](#), [National  
 39 Medical Association 123<sup>rd</sup> Annual Convention and Scientific Assembly](#) and [National Colloquium  
 40 on African American Health](#), [Association of American Indian Physicians 53<sup>rd</sup> Annual Meeting  
 41 and Health Conference](#), [National Council of Asian Pacific Islander Physician's He Huliau i ka  
 42 Pono Conference](#), [GLMA's 43<sup>rd</sup> Annual Conference on LGBTQ+ Health](#), among others. Staff  
 43 gained insights into incorporating inclusive practices into the AMA's work.
- 44 • The AMA's Truth, Healing, and Reconciliation Taskforce (TRHT) focused on organizational  
 45 transformation within and beyond the AMA toward restorative justice to promote truth,  
 46 reconciliation and healing in medicine and medical education. In 2025, the TRHT taskforce  
 47 concluded after two years having engaged six professional societies, three health care  
 48 organizations and two institutions. There was a total of six education sessions focused on  
 49 restorative justice in medicine with a total of 285 physicians in attendance across all sessions.
- 50 • 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

1 focused on promoting equitable practices and diversity in the admissions process by forging more  
 2 productive relationships between the AMA and underrepresented physician and student  
 3 organizations. A total of six convenings were held to foster collaboration between participants  
 4 with the hope of developing common approaches that will leverage collective influence. The  
 5 participating organizations included: the National Medical Association, National Hispanic  
 6 Medical Association, Association of American Indian Physicians, National Council of Asian  
 7 Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical  
 8 Student Association, Association of Native American Medical Students and Student National  
 9 Medical Association.

10  
 11 Policy Development

12 The following are some of the relevant accomplishments toward policy development during 2025:  
 13

- 14 • Optimal health outcomes-related policy priorities can be seen throughout the AMA’s engagement  
 15 with Congress, the Administration, state legislatures, and other policymakers, in the form of  
 16 advocacy letters, presentations and testimony to state legislatures, national and state medical  
 17 organizations and countless additional opportunities that engaged organized medicine and  
 18 policymakers. In 2025, the AMA continued to actively voice support for:
  - 19 ○ International medical graduates;
  - 20 ○ Migration and refugee population health and safety;
  - 21 ○ Nutrition programs expansion and culturally respectful dietary guidelines;
  - 22 ○ Medicaid coverage expansion;
  - 23 ○ Medicaid and Children’s Health Insurance Program coverage extension;
  - 24 ○ Maternal and child health programs;
  - 25 ○ Protecting reproductive health;
  - 26 ○ Advancing data privacy principles and protecting the abuse/misuse of sensitive health  
 27 data;
  - 28 ○ Protections for physicians who seek care for wellness and burnout;
  - 29 ○ Student loan accessibility and adequacy;
  - 30 ○ Increased funding for graduate medical education;
  - 31 ○ Telehealth flexibilities in Medicare;
  - 32 ○ Reducing the prior authorization burden on patients; and
  - 33 ○ Addressing quality and administrative barriers in Medicare Advantage and other  
 34 insurance plans.
- 35 • The AMA continues to amplify voices of historically underrepresented individuals through its  
 36 litigation efforts. Litigation efforts in 2025 ranged across topics including preventive care costs  
 37 under the Affordable Care Act (ACA), smoking cessation efforts and regulations, access to health  
 38 care and protecting the patient-physician relationship, among others. The AMA’s work in the  
 39 courts helped achieve favorable outcomes in several litigation efforts in addition to supporting  
 40 state medical societies’ efforts.
- 41 • The AMA’s Office of International Relations (OIR) reviewed the World Medical Association’s  
 42 (WMA) policies through an optimal health outcomes lens. The AMA contributed to the revision  
 43 of the [WMA's Statement on Trans People](#), supported the reaffirmation of the [WMA’s resolution  
 44 on human rights violation against Uighur People in China](#), and contributed to the [WMA’s  
 45 Statement on Ageing](#), advocating for aging physicians' contributions.
- 46 • The AMA continued to update internal practices in line with inclusion efforts. For example, the  
 47 AMA continues to work toward identifying and replacing offensive terminology across the  
 48 enterprise through institutional level policy. The AMA conducted a comprehensive search for  
 49 outdated terms within its IT systems and has embarked on instituting these updates to replace  
 50 harmful language.

1 Research

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

- 3
- 4 • The AMA continues to be a partner on the National Quality Forum’s [Advancing Collection of](#)  
5 [Standardized Symptoms Data](#). The initiative aims to engage physicians in data standard  
6 development by standardized patient symptom data across care settings to improve diagnosis,  
7 measurement and quality of care. The initiative focuses on improving patient-focused outcomes.
- 8 • In 2025, the [AMA Guides to the Evaluation of Permanent Impairment Sixth Edition](#) updated its  
9 pulmonary function chapter in accordance with existing AMA policies on race as a social  
10 construct and national standards of care. Specifically, a race-neutral approach to pulmonary  
11 function test interpretation algorithms was implemented by reporting and interpreting results  
12 using average reference equations rather than using race-based calculations. An additional update  
13 was the acknowledgement that pulse oximetry can have measurement errors in people with dark  
14 skin pigmentation and a call to mitigate these errors whenever possible.
- 15 • AMA staff co-authored more than 30 peer reviewed publications, including papers in Journal of  
16 the National Medical Association, JAMA Network Open, New England Journal of Medicine and  
17 Journal of General Internal Medicine, as well as contributed to the American College of  
18 Cardiology and American Heart Association Joint Committee on Clinical Practice Guidelines.
- 19 • The AMA Journal of Ethics published optimal health outcomes-related issues such as [Surgical](#)  
20 [Care of Incarcerated Patients](#) (April 2025), [Private Equity in Health Care](#) (May 2025), [Rural US](#)  
21 [Emergency Medical Services](#) (July 2025) and [Screening Children for Structural Drivers of Health](#)  
22 (September 2025).
- 23 • The JAMA Network continued curating and sharing digital content relating to health outcomes  
24 across its publications, distributed to more than 13,000 subscribers. As an example, the JAMA  
25 Network launched the [JAMA+ Women’s Health](#), a new digital resource aimed to elevate the  
26 visibility and accessibility of trusted, peer-reviewed content that advances health care for women  
27 across the globe. Recognizing that women’s health is comprehensive, [JAMA+ Women’s Health](#)  
28 showcases rigorous studies that include or focus exclusively on women from across JAMA and  
29 the 12 JAMA Network journals. Furthermore, the AMA contributed to the JAMA publication  
30 [Toward a Safer World by 2040](#), capturing proceedings from the JAMA Summit on Firearm  
31 Violence, charting an innovative roadmap toward reduction in firearm harms by 2040.
- 32 • The JAMA Network held its quarterly Equity, Diversity, and Inclusion (EDI) editor meetings to  
33 support EDI related concerns and share best practices across the network. Additionally, JAMA  
34 Network published a Research Letter titled [Equity, Diversity, and Inclusion Concerns from JAMA](#)  
35 [Network Peer Reviewers](#), which discussed results related to EDI framing, methods, terminology  
36 and language concerns gathered across all JAMA Network journals’ peer reviewer forms. Results  
37 were also presented at the 2025 Peer Review Congress.
- 38 • Diverse representation among AMA publications remained a goal in 2025. The AMA updated 30  
39 illustrations for the 2026 CPT Professional book to reflect all populations. Input was gathered  
40 from internal and external reviewers. This progress is contributing to the AMA’s five-year plan to  
41 update over 100 CPT Professional book illustrations to depict authentic and diverse individuals.
- 42 • The AMA integrated equitable practices across its market and user experience research by  
43 aligning research questions with AMA’s data privacy practices, ensuring populations of focus  
44 were appropriately represented and considering vendors based on their expertise and experience  
45 working with participants involved in the research. Additionally, the AMA conducted a market  
46 assessment to analyze how other organizations have diversified medical illustrations in their  
47 materials.
- 48
- 49

1 CONCLUSION

2

3 This report highlights only a portion of the work accomplished in 2025. AMA staff continued to make  
4 great strides and fulfilled their Business Unit annual goals. Staff devoted countless hours to learning how  
5 they can collaborate to improve health outcomes and apply those insights within and beyond the  
6 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.

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

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

11

- 12 1. Provide a summary of findings and actionable recommendations from both internal and  
13 external advocacy consultants regarding Medicare payment reform. The report must  
14 primarily focus on barriers identified, gaps in the current strategy, and specific  
15 recommendations for improving and accelerating advocacy efforts.
- 16  
17 2. Share with its members comprehensive reports on our Medicare payment reform advocacy  
18 efforts, including consultant findings on major barriers, strategy gaps, and  
19 recommendations for improvement, at both the Interim and Annual Meetings beginning at  
20 I-25, and more frequently as legislative dynamics dictate.

21

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

25

26 **AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM**

27

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

34

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

37

- 38 • Automatic annual payment updates based on the Medicare Economic Index (MEI);
- 39 • Updated policies governing when and how budget neutrality adjustments are made;

- 1 • Simplified and clinically relevant policies under the Merit-based Incentive Payment System;
- 2 and
- 3 • Greater opportunities for physician practices that want to transition to advanced alternative
- 4 payment models (APMs).

5  
6 At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment  
7 system lie four central pillars that highlight our strategic approach: legislative advocacy; regulatory  
8 advocacy; Federation engagement; and grassroots, media, and outreach initiatives. Grounded in  
9 principles endorsed by a unified medical community, our legislative efforts drive the advancement  
10 of policies that foster payment stability and promote value-based care. We actively champion  
11 reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers  
12 for Medicare & Medicaid Services (CMS) and the White House to address impending challenges  
13 and ensure fair payment policies. Our Federation engagement fosters unity and consensus within  
14 the broader medical community, pooling resources and strategies to amplify our collective voice.  
15 Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers  
16 and the public, ensuring our mission is well-understood and supported from all quarters. Together,  
17 these pillars fortify our endeavors to achieve a more rational Medicare physician payment system  
18 that truly benefits all.

19  
20 *Legislative Advocacy*

21  
22 Physicians continue to face significant financial instability under the current Medicare physician  
23 payment system. The calendar year (CY) 2025 Medicare Physician Fee Schedule finalized a 2.83  
24 percent reduction in physician payment rates, continuing a pattern of recurring cuts that has  
25 persisted for several years.

26  
27 In response to sustained advocacy from the AMA, Federation partners, and the broader physician  
28 community, Congress included a provision in the One Big Beautiful Bill Act (OB3) providing a 2.5  
29 percent Medicare physician update for 2026 to partially mitigate these reductions.

30  
31 While this action provided temporary relief, it addressed only a portion of the cut and did not  
32 resolve the structural flaws that continue to destabilize Medicare physician payment.

33  
34 Beginning in 2026, statutory updates of 0.25 percent for most physicians and 0.75 percent for  
35 qualifying participants in advanced alternative payment models take effect under MACRA, but  
36 these updates are not tied to inflation and fall far short of projected increases in practice costs.

37  
38 CMS estimates that the MEI, which measures changes in physician practice costs, will increase by  
39 2.7 percent in 2026, further widening the gap between payment and the cost of delivering care.

40  
41 As a result, Medicare physician payments have effectively declined by approximately 33 percent  
42 since 2001 when adjusted for inflation in practice costs.

43  
44 During this period, physician practices have experienced significant increases in expenses related  
45 to staffing, technology, regulatory compliance, and facility costs. This growing imbalance is  
46 placing increasing pressure on physician practices across the country. Small, rural, and independent  
47 practices are particularly vulnerable to continued payment instability.

48  
49 When practices are forced to close, consolidate, or limit the number of Medicare patients they can  
50 treat, access to care is threatened for millions of seniors and patients with disabilities.

1 Expanding the physician workforce alone will not solve these access challenges if newly trained  
2 physicians enter a Medicare system that remains financially unsustainable.

3  
4 Fixing the broken Medicare physician payment system therefore remains one of the AMA's highest  
5 legislative priorities. The AMA continues to work closely with congressional leaders and  
6 Federation partners to move beyond the annual cycle of payment cuts and temporary patches and  
7 instead enact durable structural reforms that stabilize physician payment and support patient access  
8 to care.

9  
10 As a result of sustained advocacy by the AMA and the physician community, bipartisan legislation  
11 has been introduced that reflects elements of the AMA-developed framework—Characteristics of a  
12 Rational Medicare Physician Payment System. The AMA continues to urge Congress to advance  
13 several key reforms designed to modernize the Medicare physician payment system and restore  
14 long-term stability.

15  
16 The current Medicare physician payment system is characterized by stagnant base payments, the  
17 absence of permanent annual inflationary updates, and excessive administrative burdens. Unlike  
18 hospitals and other Medicare providers, physicians do not receive automatic inflationary  
19 adjustments tied to rising practice costs. This pattern of recurring reductions and structural  
20 instability is undermining the financial viability of physician practices nationwide.

21  
22 To address these challenges, the AMA continues to advocate for several core legislative reforms  
23 designed to stabilize and modernize Medicare physician payment.

24  
25 Medicare Reform: Automatic Annual Inflation-Based Updates

26  
27 First, the AMA continues to advocate for the establishment of a permanent annual inflationary  
28 update for physician services tied to the MEI to ensure that Medicare physician payments more  
29 accurately reflect the real costs of delivering care. Unlike hospitals and other Medicare providers,  
30 physicians do not receive automatic inflationary adjustments, leaving practices increasingly  
31 vulnerable as staffing, technology, compliance, and other operational expenses continue to rise. In  
32 the previous Congress, H.R. 2474, the Strengthening Medicare for Patients and Providers Act,  
33 would have provided a permanent MEI-based update and garnered more than 170 bipartisan  
34 cosponsors. The AMA continues to support similar legislation, including H.R. 6160 introduced in  
35 the 119th Congress, which would establish a permanent MEI-based update and help restore  
36 stability and predictability to Medicare physician payment.

37  
38 Medicare Payment Reform: Budget Neutrality

39  
40 Second, the AMA continues to advocate for modernization of Medicare's budget neutrality  
41 requirements to prevent destabilizing payment reductions that occur when services are revalued or  
42 new services are added to the physician fee schedule. Current statutory thresholds and inaccurate  
43 utilization projections frequently trigger across-the-board reductions in physician payments,  
44 contributing to instability in the Medicare physician payment system. The AMA supports  
45 legislative efforts to raise the budget neutrality threshold and improve the accuracy and  
46 transparency of utilization estimates for newly unbundled services assigned projected utilization.  
47 Legislation introduced in the previous Congress, H.R. 6371, the Provider Reimbursement Stability  
48 Act, provides a framework for updating these outdated statutory requirements. The AMA continues  
49 to work with congressional leaders to advance legislation that would modernize budget neutrality  
50 policies and promote greater predictability in Medicare physician payment.

1 Medicare Payment Reform: Revising the MIPS Program

2  
3 Third, the AMA continues to advocate for meaningful reforms to the Merit-based Incentive  
4 Payment System (MIPS) to reduce administrative burden and better align performance  
5 measurements with meaningful improvements in patient outcomes. While MIPS was intended to  
6 promote value and quality within the Medicare program, its current structure imposes significant  
7 reporting requirements that disproportionately affect small, rural, and independent physician  
8 practices, often without demonstrable improvements in quality of care. The AMA is working with  
9 Federation organizations on the introduction and advancement of legislative and regulatory reforms  
10 that streamline reporting requirements, improve measure relevance, and reduce unnecessary  
11 administrative complexity so that physicians can devote more time and resources to patient care  
12 rather than compliance activities.

13  
14 *119th Congress AMA Advocacy Highlights*

15  
16 In early 2025, Representatives Greg Murphy, MD, (R-NC) and Jimmy Panetta (D-CA) introduced  
17 H.R. 879, the Medicare Patient Access and Practice Stabilization Act, bipartisan legislation  
18 designed to address the 2.83 percent Medicare physician payment cut that took effect on January 1,  
19 2025, and to provide a positive payment update to help stabilize physician practices. The  
20 legislation reflected growing bipartisan concern about the financial pressures facing physician  
21 practices and the potential impact of continued payment instability on patient access to care.

22  
23 The AMA worked closely with the bill sponsors and congressional physician leaders to support the  
24 legislation and ensure it reflected the real-world costs of delivering care and the operational  
25 challenges facing physician practices. The bill quickly became a focal point for physician  
26 advocacy, drawing broad support across the physician community. More than 120 bipartisan House  
27 members cosponsored the legislation, and over 80 physician organizations, including all 50 state  
28 medical associations, joined a coalition letter urging Congress to act.

29  
30 Although H.R. 879 was not ultimately enacted as a standalone measure, the legislation played an  
31 important role in elevating Medicare physician payment reform as a priority issue for Congress.  
32 The bill helped frame the policy debate around the need for immediate relief from payment cuts  
33 while reinforcing the broader call for structural reforms to stabilize the Medicare physician  
34 payment system and protect patient access to care.

35  
36 *Alternative Payment Model (APM) Progress and H.R. 7148*

37  
38 H.R. 7148, the Consolidated Appropriations Act, 2026, included several important AMA-supported  
39 provisions restoring incentives for participation in advanced Alternative Payment Models (APMs).  
40 Specifically, the legislation reinstated APM incentive payments at 3.1 percent for the 2026  
41 performance year (2028 payment year) and reduced the Qualifying Participant (QP) revenue  
42 threshold from 75 percent back to 50 percent for the same performance year. These changes help  
43 restore meaningful incentives for physician participation in value-based care and reduce barriers  
44 that had limited participation following the expiration of the original APM bonus and the automatic  
45 increase in the QP threshold in 2025.

46  
47 The law also includes several Medicare extenders that expire at the end of 2026. As a result,  
48 Congress will again need to address key Medicare payment policies, creating an opportunity for the  
49 AMA to continue advancing broader Medicare physician payment reforms, including efforts to  
50 secure a physician payment update for 2027.

1 *National Advocacy Conference – February 2026*

2

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

9

- 10 • Provides annual inflationary updates tied to practice costs
- 11 • Reforms budget neutrality
- 12 • Improves MIPS
- 13 • Expands APM options

14

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

17

18 *Grassroots, Media, and Outreach*

19

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

26

27 The AMA has a dedicated Medicare payment reform web site, [www.FixMedicareNow.org](http://www.FixMedicareNow.org), which  
28 includes a range of AMA-developed advocacy resource material, updated payment graphics, and a  
29 new “Medicare basics” series of papers describing in plain language specific challenges  
30 presented by current Medicare payment policies and recommendations for reform.

31

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

36

- 37 • 103+ million in earned media and ad impressions
- 38 • 3.9+ million media and ad engagements
- 39 • 944,000+ pageviews
- 40 • 910,000+ site users
- 41 • 100,000+ contacts to Congress
- 42 • 260+ third-party media placements and grass top contacts made in key Congressional districts

43

44 *Senate Legislation and H.R. 1*

45

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

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

6  
7 The AMA advocacy team was instrumental in the development and inclusion of these House-  
8 passed Medicare provisions. Section 44304, which linked the update to inflation in practice costs  
9 using the MEI, reflected AMA policy and decades of advocacy, and was recently echoed in  
10 recommendations by the Medicare Payment Advisory Commission (MedPAC).

11  
12 These provisions passed the House of Representatives. However, the Senate scaled the proposal  
13 back to a temporary 2.5 percent update for 2026.

14  
15 The final version of H.R. 1, passed by the Senate, retained only the temporary one-year 2.5 percent  
16 conversion factor update—with no permanent, inflation-adjusted fix. Still, the inclusion of any  
17 update represented forward movement and provides important momentum for continued advocacy  
18 in the 119th Congress.

#### 19 20 *Federation Engagement*

21  
22 The AMA continues to work closely with state medical associations and national medical specialty  
23 societies to build alignment around shared principles for Medicare physician payment reform.  
24 Through ongoing coordination with Federation partners, the AMA has strengthened advocacy  
25 efforts, reinforced consistent policy messaging, and demonstrated broad physician support for  
26 legislative solutions that stabilize Medicare physician payment and protect patient access to care.

27  
28 At the same time, the AMA continues to advance several legislative initiatives aimed at addressing  
29 structural challenges within the Medicare physician payment system. AMA advocacy staff are  
30 working closely with House Ways and Means Committee Chairman Jason Smith (R-MO) and  
31 Representative Greg Murphy, MD, (R-NC) on the reintroduction of updated legislation to reform  
32 Medicare's budget neutrality policies. As part of this effort, bipartisan staff from the relevant  
33 House and Senate committees of jurisdiction recently participated in a technical assistance briefing  
34 with CMS, confirming that the proposed reforms could be implemented operationally. The AMA is  
35 also working to secure bipartisan support for the legislation, including Democratic cosponsors from  
36 the Ways and Means and Energy and Commerce Committees.

37  
38 In parallel, the AMA is advancing legislation to reform MIPS. This proposal was developed  
39 through a physician-led Medicare MIPS working group convened by the AMA and reflects  
40 extensive collaboration among physician organizations to identify practical reforms that reduce  
41 administrative burden, improve fairness, and preserve incentives for high-quality care. The AMA is  
42 currently working with congressional offices and physician organizations to finalize the legislation  
43 and build support for its introduction.

#### 44 45 *Advocacy with MedPAC and Looking Forward*

46  
47 The AMA continues to engage with MedPAC as it evaluates the adequacy of Medicare physician  
48 payment and develops recommendations to Congress. During its December 2025 meeting,  
49 MedPAC discussed a potential recommendation to update Medicare physician payment rates in  
50 2027 by current law plus 0.5 percent, which would result in an update of approximately 1.25  
51 percent for clinicians participating in advanced alternative payment models and 0.75 percent for

1 other physicians. However, the cost of providing care is expected to increase by approximately 2.1  
2 percent, meaning that such a recommendation would allow the gap between physician payment and  
3 practice cost inflation to continue widening.

4  
5 In recent comments submitted following the meeting, the AMA urged MedPAC to recommend that  
6 Congress update physician payment in 2027 by the full increase in the MEI. The AMA emphasized  
7 that aligning physician payment updates with practice cost inflation is necessary to improve  
8 payment stability, preserve private physician practices, and maintain patient access to care.

9  
10 The AMA also highlighted MedPAC data showing emerging access challenges for Medicare  
11 beneficiaries. In 2025, 29 percent of beneficiaries reported waiting six or more weeks to see a new  
12 primary care physician and 31 percent reported similar waits to see a new specialist. At the same  
13 time, growth in spending under the Medicare Physician Fee Schedule has remained modest  
14 compared to other components of Medicare Part B, with physician fee schedule spending per  
15 beneficiary increasing far more slowly than overall Part B spending in recent years.

16  
17 The AMA will continue working with MedPAC to ensure that its recommendations to Congress  
18 reflect the growing gap between physician payment and practice cost inflation and the potential  
19 implications for patient access to care.

#### 20 21 *Call to Action*

22  
23 Congress must urgently address a broken Medicare payment system that places enormous financial  
24 pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- 25
- 26 • Enact a positive update to keep up with inflation; and
- 27 • Implement a long-term fix that ensures payment adequacy and stability, including reforms to
- 28 budget neutrality and MIPS and expanded APM options.
- 29

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

33  
34 Fixing this system will remove a major financial stressor for physicians, protect patient access, and  
35 stabilize our health care infrastructure. The House-passed provisions of H.R. 1 provide a critical  
36 foundation for comprehensive reform. Ensuring regular, adequate payment updates is vital to  
37 practice sustainability, advancing value-based care models, and safeguarding access to care for  
38 Medicare beneficiaries—especially in rural and underserved communities, where practices treat  
39 four times as many Medicare patients as those in metropolitan areas.

40  
41 As physicians across the country continue to share their stories and advocate for reform, there is  
42 hope that our united efforts will eventually break through the political and financial barriers that  
43 have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and  
44 effective Medicare physician payment system is achieved.

#### 45 46 STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

47  
48 In response to Policy D-400.981, the AMA is conducting a comprehensive review of its Medicare  
49 payment reform advocacy strategy. This effort includes evaluating opportunities to engage external  
50 advocacy consultants and refining internal processes to identify barriers, assess strategic gaps, and  
51 develop targeted recommendations to strengthen ongoing reform efforts. While this work is

1 ongoing at the time this report was prepared, the AMA remains committed to advancing this  
2 review and will provide an update at the 2026 Interim Meeting.

3

4 CONCLUSION

5

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

10

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

## 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.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-A-26

Subject: AMA Public Health Strategy Update

Presented by: David H. Aizuss, MD, Chair

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2 Health Systems” adopted by House of Delegates (HOD) at I-21 directed our American Medical  
3 Association (AMA) to:

4  
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7       progress.

8  
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11 legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

12  
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14 critical public health work to the HOD.

15  
16 DISCUSSION

17  
18 *What is Public Health?*

19  
20 Since its founding in 1847, the AMA’s mission has been “to promote the art and science of  
21 medicine and the betterment of public health.” According to the Centers for Disease Control and  
22 Prevention (CDC), public health is “the science and art of preventing disease, prolonging life, and  
23 promoting health through the organized efforts and informed choices of society, organizations,  
24 public and private communities, and individuals.”<sup>1</sup> Public health promotes and protects the health  
25 of people and the communities where they live, learn, work and play.<sup>2</sup> Public health practice is a  
26 different field than clinical medicine with different motivating values, responsibilities, and goals.<sup>3</sup>  
27 While a doctor treats people who are sick, those working in public health try to prevent people  
28 from getting sick or injured in the first place. A public health professional’s duty is to the  
29 community rather than an individual patient.

30  
31 *Connection with Health Equity*

32  
33 It is important to acknowledge that health equity is a central concept in public health and is  
34 essential to improving the health of populations. The AMA’s health equity strategy recognizes that  
35 structural and social drivers of health inequities shape a person’s and community’s capacity to  
36 make healthy choices, noting that downstream opportunities provided by the health care system  
37 and individual-level factors are estimated to only contribute 20 percent to an individual’s overall  
38 health and well-being, while upstream opportunities of public health and its structural and social  
39 drivers account for 80 percent of impact on health outcomes.<sup>4</sup> Progress towards the AMA’s health

1 equity strategy is reported in the Board of Trustees (BOT) annual health equity report. (See BOT  
2 Report 9-A-26, “American Medical Association Health Equity Annual Report.”)  
3

#### 4 AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES 5

##### 6 **1. Promote evidence-based clinical and community preventive services.** 7

###### 8 *A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory* 9 *Committee on Immunization Practices (ACIP), and the Community Preventive Services Task* 10 *Force (CPSTF) and support the dissemination of recommendations to physicians.* 11

12 Last year saw major disruptions to federal advisory committees whose goal is to develop  
13 recommendations for clinical and community preventive services, this included the longest  
14 government shutdown in history in the fall of 2025. CPSTF did not convene at their normally  
15 scheduled times to discuss evidence-based recommendations in 2025. CPSTF met for the first time  
16 in February 2026 after nearly a year and a half of not convening.  
17

18 In early 2025, the structure of the USPSTF was being challenged in the courts. On June 27, 2025,  
19 the U.S. Supreme Court ruled in *Kennedy v. Braidwood Management, Inc.* that the structure of  
20 the USPSTF was constitutional. The Court upheld the Affordable Care Act's (ACA) requirement  
21 that private insurers cover USPSTF "A" and "B" rated preventive services without cost-  
22 sharing. The Supreme Court also confirmed the HHS Secretary's authority to remove and appoint  
23 members of the task force.  
24

25 The USPSTF did not convene at their normally scheduled times in July and November of 2025.  
26 The USPSTF was expected to meet early March of 2026, but that meeting was postponed. Task  
27 Force recommendations are not being published on a regular basis and there are concerns about  
28 staffing support for the task force within the Agency for Healthcare Research and Quality given  
29 reductions in force at the agency.  
30

- 31 • On July 27, 2025, the AMA sent a [letter](#) to the Secretary of the Department of Health and  
32 Human Services (HHS), expressing deep concern with the reports of his intention to  
33 remove all of the members of the USPSTF and commit to the long-standing process of  
34 regular meetings to ensure their important work can continue without interruption.  
35

36 The ACIP has continued to meet, but the removal and replacement of all ACIP members, as well as  
37 changes to the vaccine recommendations have been extremely concerning. The following list  
38 represents the AMA’s response to the changes to ACIP:  
39

- 40 • On June 9, 2025, the AMA issued a [statement](#) on the removal of the 17 sitting members of  
41 ACIP and noting that it undermines trust in a process that has saved countless lives.
- 42 • On June 12, 2025, the AMA issued a [statement](#) on new members of the ACIP selected  
43 without transparency and proper vetting.
- 44 • On June 13, 2025, the AMA sent a [letter](#) to Senate leadership regarding the actions by  
45 HHS to terminate the appointments of the 17 voting members of the ACIP and urged an  
46 inquiry into the circumstances surrounding the decision to remove and replace all sitting  
47 members.
- 48 • On June 18, 2025, the AMA sent a [letter](#) to HHS expressing significant concern regarding  
49 the recent action to terminate the entirety of the membership of the ACIP.

- 1 • On August 1, 2025, ACIP medical society liaison organizations issued a [joint statement](#)  
2 regarding their removal from ACIP vaccine workgroups.
- 3 • On September 19, 2025, the AMA issued a [statement](#) on ACIP's new MMRV vaccine  
4 recommendations.
- 5 • Oct. 15, 2025, the AMA joined an [amicus brief](#) in the case of *AAP vs. Kennedy* calling for  
6 government recommendations regarding the COVID-19 vaccine to reflect the full body of  
7 medical evidence and to follow the statutorily process for the provision of vaccine  
8 guidance.
- 9 • On December 5, 2025, the AMA issued a [statement](#) on ACIP vote to weaken the birth-dose  
10 recommendation for the hepatitis B vaccine.
- 11 • On December 15, 2025, the AMA issued a [statement](#) on the CDC hepatitis B birth dose  
12 decision.
- 13 • On January 5, 2026: the AMA issued a [statement](#) on changes to the childhood vaccine  
14 schedule.
- 15 • On January 23, 2026, the AMA issued a [statement](#) on the ACIP chair's comments on polio,  
16 routine vaccinations.

17  
18 The AMA House of Delegates voted in November of 2025 to amend AMA policies to support  
19 ACIP recommendations as of May 1, 2025, as well as subsequent recommendations by national  
20 medical specialty societies. AMA statements in support of evidence-based vaccine  
21 recommendations were as follows:

- 22  
23 • On June 25, 2025, the AMA and 79 medical societies issued a [joint statement](#) backing  
24 vaccination against respiratory viruses.
- 25 • On October 30, 2025, the AMA issued a [statement](#) urging vaccination in advance of  
26 respiratory virus season.
- 27 • On January 26, 2026, the AMA formally endorsed [the 2026 AAP childhood and adolescent](#)  
28 [immunization scheduled](#), which recommends routine, comprehensive immunization from  
29 birth through 18 years.
- 30 • On February 3, 2026, the AMA [urged](#) the public to get vaccinated against measles as cases  
31 rise and the U.S. at real risk of losing its measles elimination status.
- 32 • On February 10, 2026, the AMA and the Vaccine Integrity Project [announced](#) the launch  
33 of a structured, evidence-based review process to assess vaccine safety and effectiveness  
34 for the 2026-2027 respiratory season. The review will focus on immunizations for  
35 influenza, COVID-19, and respiratory syncytial virus (RSV) and will help inform the  
36 recommendations developed by national medical specialty societies.

37  
38 ***B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (work led by the***  
39 ***Center for Optimal Health Outcomes team)***

40  
41 The AMA is committed to improving the health of the nation and reducing the burden of chronic  
42 diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death  
43 in the U.S., accounting for one in four deaths among adults.<sup>5</sup> Two major risk factors for CVD are  
44 hypertension and type 2 diabetes.

- 45  
46 • To prevent CVD and address related health inequities, the AMA is developing and  
47 disseminating CVD prevention solutions in collaboration with health care and public health  
48 leaders. These solutions educate clinical care teams and patients, guide health care  
49 organizations (HCOs) in clinical quality improvement and promote policy changes to  
50 remove barriers to care. The AMA disseminates these solutions through strategic alliances

1 with various organizations including the CDC, the American Heart Association (AHA),  
 2 and West Side United in Chicago.

- 3 • The [AMA MAP](#)™ Hypertension clinical quality improvement program was designed to  
 4 improve hypertension management and control. The free program has demonstrated  
 5 effectiveness in a variety of health care settings from large health care organizations  
 6 (HCO) to community health centers. Participating HCOs are provided with clinical based  
 7 practice facilitation and a personalized dashboard with performance metrics.<sup>6</sup> The AMA  
 8 MAP™ set of solutions is expanding to include management for other cardiovascular  
 9 disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.
- 10 • AMA MAP™ houses a suite of tools and resources designed to help organizations build  
 11 and integrate diabetes prevention strategies into their organizations. AMA has worked with  
 12 more than 80 health care organizations across the country to increase identification and  
 13 management of patients with prediabetes.
- 14 • The AMA was awarded a multi-year CDC grant to implement three projects aimed at  
 15 improving the quality of cardiovascular disease-related preventive care in Community  
 16 Health Centers/Federally Qualified Health Centers. The funding will allow AMA to scale  
 17 its existing quality improvement program. The goal is to help 500,000 patients achieve  
 18 blood pressure control.
- 19 • Additionally, the AMA, in collaboration with the AHA, developed [Target: BP](#)™, which  
 20 recognizes organizations that have achieved milestones in their commitments to improving  
 21 blood pressure control.
- 22 • The AMA established the [U.S. Blood Pressure Validated Device Listing](#) (VDL)—a trusted  
 23 resource for clinicians, care teams, and patients alike. The VDL features blood pressure  
 24 devices independently validated for clinic accuracy.

25  
 26 ***C. Counseling Patients on Nutrition to Promote a Healthy Diet***

27  
 28 The AMA strongly supports the role of physicians in counseling patients on healthy diets and  
 29 nutrition. The AMA has made it a priority to help physicians translate nutrition science into  
 30 practical advice for patients, recognizing that dietary choices are key drivers of chronic diseases  
 31 such as heart disease, diabetes, and obesity.

- 32  
 33 • On May 30, 2025, the AMA sent a [letter](#) to the Food and Drug Administration (FDA) on  
 34 the proposed rule entitled “Food Labeling: Front-of-Package Nutrition Information.” The  
 35 letter noted support for requiring most foods to display a nutrition facts information box  
 36 on the principal display panel regarding the relative levels of saturated fat, sodium, and  
 37 added sugars in a serving of food.
- 38 • On August 15, 2025, the AMA [commented](#) on the Alcohol and Tobacco Tax and Trade  
 39 Bureau’s (ATTB) proposed rule entitled “Alcohol Facts Statements in the Labeling of  
 40 Wines, Distilled Spirits, and Malt Beverages.” The letter indicated the AMA’s strong  
 41 support for the creation of an alcohol facts statement, which will lead to greater consumer  
 42 understanding about the associated dietary and health impacts of consuming alcoholic  
 43 products.
- 44 • On September 29, 2025, the AMA [responded](#) to a Request for Information (RFI) from the  
 45 FDA and the U.S. Department of Agriculture (USDA) titled “Ultra-Processed Foods;  
 46 Request for Information.” The letter shared concern about the risks posed by ultra-  
 47 processed foods (UPFs) and agreed that a uniform definition of UPFs could benefit  
 48 research, policymaking, and members of the public seeking to make informed and healthy  
 49 nutrition choices.

- 1 • On January 7, 2026, the AMA released a [press statement](#) applauding the Administration’s  
2 new Dietary Guidelines for spotlighting the highly processed foods, sugar-sweetened  
3 beverages, and excess sodium that fuel heart disease, diabetes, obesity, and other chronic  
4 illnesses.
- 5 • On March 5, 2026, the AMA joined the Department of Health and Human Services (HHS)  
6 and the U.S. Department of Education at a [convening](#) of leaders from 53 of the nation’s  
7 top medical schools across 31 states to announce commitments to meaningful nutrition  
8 training beginning in the next academic year.
- 9 • On March 24, 2026, the AMA [announced](#) the launch of a nutrition education initiative to  
10 equip physicians and medical students with practical, evidence-based knowledge and tools  
11 to help patients live healthier lives. The program will feature webinars, roundtables, and  
12 additional resources on the AMA Ed Hub™. This work is part of an ongoing effort by the  
13 AMA to advance nutrition education across the medical education continuum and elevate  
14 nutrition as a core component of patient care.

#### 15 16 ***D. Screening and Reducing Risk for Dementia (CDC funded)***

17  
18 To advance the “[Navigating Brain Health and Dementia Project](#),” the AMA has completed and  
19 continues to advance the following activities and deliverables:

- 20  
21 • The AMA completed a needs assessment to better understand the current knowledge, daily  
22 practices, challenges, and training needs of physicians and other health care professionals  
23 in the prevention, screening, diagnosis, and treatment of Alzheimer’s disease and related  
24 dementias (ADRD). The findings from the needs assessment are being used to inform the  
25 development of educational materials and were submitted as an abstract to the 2026  
26 Alzheimer's Association International Conference. A peer-reviewed publication is also  
27 being drafted.
- 28 • The AMA convened a work group of clinicians and researchers with subject matter  
29 expertise in ADRD research, clinical care, and education to provide feedback and guidance  
30 on the development of educational materials. The workgroup has participated in monthly  
31 meetings, provided feedback on the design and interpretation of a needs assessment,  
32 contributed topic and content ideas for upcoming CME modules and short videos, and will  
33 serve as subject matter experts on three upcoming webinars.
- 34 • The AMA will host three webinars on ADRD in March, April, and May of 2026. The  
35 webinar topics focus on (1) [Detection and Diagnosis of Dementia in Primary Care](#), (2)  
36 Lifestyle Approaches to Promote Brain Health: Maintaining Cognitive Health Over the  
37 Life Course, and (3) Building a Stronger Brain Health Care Team.
- 38 • There are also two continuing medical education (CME) modules in development. The first  
39 is comprised of three mini modules focused on (1) Recognizing Cognitive Concerns in  
40 Primary Care Settings, (2) Choosing and Applying Diagnostic Aids for Cognitive  
41 Impairment and Dementia, and (3) Communicating Results of Cognitive Assessments and  
42 Next Steps. A second module will focus on post-diagnosis care.

#### 43 44 ***E. Improving the implementation of routine screening for HIV, STI, Viral Hepatitis and latent*** 45 ***tuberculosis (LTBI). (CDC funded)***

46  
47 The AMA continues to work on the “[Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in](#)  
48 [Hospitals, Health Systems and Other Healthcare Settings](#)” project. The scope of this project has  
49 included developing, piloting and launching a toolkit that outlines ways to increase routine  
50 screening for HIV, STIs, viral hepatitis and LTBI. The toolkit contains two different sets of

1 strategies – one targeted to community health centers (CHCs) and a second to emergency  
 2 departments (EDs). In the past year the AMA has been working to scale the adoption and  
 3 implementation of the quality improvement strategies in the toolkit across CHCs and EDs.

- 4 • The toolkit was launched to the public in March of 2024.<sup>7</sup> Since its launch, the toolkit has  
 5 had over 27,000 page views, over 18,000 views of the launch series [webinars](#) and over  
 6 1,400 downloads of the PDF toolkit.
- 7 • In 2025, 15 CHCs and EDs from across the country were selected to participate in a 6-  
 8 month Community of Practice (CoP). The AMA hosted five 30-minute tele-mentoring  
 9 sessions to advance quality improvement strategies within the toolkit. The AMA also  
 10 hosted six 60-minute office hour sessions where CoP members could discuss their  
 11 challenges in implementing routine screening.
- 12 • The AMA also identified three national organizations to promote the routine screening  
 13 toolkit to their members during 2025 (Alliance Chicago, Society of Academic Emergency  
 14 Medicine, and the National Coalition of STD Directors).
- 15 • In 2026, the AMA is expanding to [host a CoP](#) that is open to any CHC or ED that wants to  
 16 start or expand routine screening for these infectious diseases. A work group of four  
 17 experts is meeting monthly to shape the hour-long office hours. Once again, the office  
 18 hours will serve as a safe place for clinicians to share their challenges and get assistance  
 19 with everything from patient education to care team workflow to EMR optimization.
- 20 • The toolkit will be expanded in 2026 with webinars focusing on improving routine  
 21 screening in specific populations with a focus on patients with substance use disorders,  
 22 patients who are pregnant, and rural populations.
- 23 • In addition to the work on the routine screening toolkit, the AMA has also received  
 24 funding from the CDC to explore barriers in accessing preventive medications including  
 25 pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and  
 26 doxycycline post-exposure prophylaxis (doxy PEP) for STIs to inform the development of  
 27 tools and resources to help overcome these barriers.
- 28 • The AMA worked with a vendor to conduct two discussion groups looking at barriers to  
 29 PrEP and doxy PEP prescribing. Five SMEs and three non-SMEs gave their thoughts on  
 30 current challenges and potential solutions. The AMA will develop a work group to use  
 31 these findings to develop targeted education and resources to improve access to these  
 32 interventions.

33  
 34 ***F. Promote evidence-based preventive services to the public.***

35  
 36 While the AMA’s primary audience has historically been physicians, there are limited instances  
 37 where the AMA has partnered on public information campaigns on select priority issues. This work  
 38 has been made possible through partnerships with other health-related organizations and the Ad  
 39 Council. The AMA will explore opportunities for future campaigns on an ongoing basis.

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

1 [GetMyFluShot.org](https://www.getmyflushot.org) for more information, including where to get a flu vaccine in their area. Some  
 2 highlights from the 2025-26 flu campaign are as follows:

- 3
- 4 • The donated media value for the current flu season reached \$1.49 million. The most  
 5 support has come from TV (\$1,024,041), closely followed by digital (\$468,499).
  - 6 • A media tour was held on December 9, 2025, featuring three spokespeople from the AMA  
 7 included 30 interviews in English and Spanish. Over 100 placements were secured across  
 8 TV, radio, and digital, with a reach of 45.1 million digital impressions and 1.1 million  
 9 broadcast impressions.
  - 10 • Across both Black and Hispanic audiences, respondents aware of the PSAs are  
 11 significantly more likely to report receiving a flu vaccine (65 percent), compared to not-  
 12 aware respondents (48 percent), based off our most recent December 2025 tracking survey.

13

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

15

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

24

25 ***A. Address the public health crisis of climate change.***

26

27 At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate  
 28 change a public health crisis that threatens the health and well-being of all individuals.” Since the  
 29 A-25 meeting, AMA has accomplished the following activities and continues to follow the [strategy](#)  
 30 to address climate change and health adopted at the I-24 HOD meeting:<sup>9</sup>

- 31
- 32 • The AMA continues to make climate change and sustainability education available via the  
 33 Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and  
 34 Equity, Stanford Medicine, AMA Journal of Ethics, the Journal of the American Medical  
 35 Association (JAMA), and the American Public Health Association (APHA).
  - 36 • In 2025, the AMA organized a three-part [webinar series](#) on climate and health, which is  
 37 available on AMA’s Ed Hub. The three webinars covered the hidden health impacts of  
 38 climate change, planning for climate resilience in the health care sector, and decarbonizing  
 39 health care.
  - 40 • The AMA is in the process of developing a CME module for physicians and trainees on  
 41 climate change and health. The focus of the module is to bring awareness to physicians  
 42 about the impact of climate change on the nation’s health and to empower physicians to  
 43 begin conversations with their patients about how climate change is affecting their health  
 44 and what they can do about it.
  - 45 • In December 2024, AMA developed and distributed a survey to physicians to assess  
 46 perceptions on climate change and health, including the level of importance and relevance  
 47 of climate change to physicians, understanding day-to-day effects of climate change that  
 48 physicians may be experiencing or anticipating experiencing in the future, and exploring  
 49 what the AMA’s role should be in supporting physicians on climate change. Findings from  
 50 this survey were presented at the APHA 2025 Annual Conference (November 2025) and an

1 abstract on the survey findings has also been accepted at National Association of City and  
 2 County Officials annual conference (April 2026). A publication intended for a peer-review  
 3 journal is drafted with intended publication in 2026.

- 4 • AMA staff moderated a panel discussion entitled “Clinician and Health System Responses  
 5 to Extreme Weather,” at the inaugural Illinois Extreme Weather and Health summit, held  
 6 on November 12-13, 2025, in Chicago, IL.
- 7 • The AMA continues to engage in the [Medical Society Consortium on Climate and Health](#)  
 8 (MSCCH), which brings together associations representing over 600,000 clinical  
 9 practitioners.<sup>12</sup> The AMA sits on the executive committee of this group and through the  
 10 MSCCH the AMA represents the U.S. to the Global Climate and Health Alliance.  
 11 Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March  
 12 2026 in Arlington, VA.
- 13 • The AMA is a member and sponsor of the [National Academy of Medicine \(NAM\) Action](#)  
 14 [Collaborative on Achieving a Climate Resilient and Sustainable Health Sector](#) (Climate  
 15 Collaborative) and is represented on the Steering Committee and served as a co-lead of the  
 16 Health Care Delivery Workgroup (Phase 1 and 2). The Health Care Delivery Workgroup  
 17 focused on three deliverables in Phase 2, which included:
  - 18 ○ Hosting the “[Building Momentum to Act on Health Care Decarbonization](#)”  
 19 Webinar Series. All recordings, slides, and resources have been published. We also  
 20 developed a 1-page overview summarizing key findings and takeaways from the  
 21 series.
  - 22 ○ [Developing a list of Key Actions for Health Professionals to Advance Sustainable](#)  
 23 [Health Care](#) (Health Professionals Shortlist), which has been published.
  - 24 ○ Developing a [Climate Journey Map: Clinical Pathway](#), which was published. We  
 25 are continuing to review new resource submission monthly with Journey Map  
 26 updates published on a quarterly basis.
  - 27 ○ The Committee’s Phase 3 work will focus on redefining quality through climate  
 28 action and building the evidence.
- 29 • Additionally, the AMA participates in the American Lung Association’s Healthy Air  
 30 Partners campaign, which is a coalition of 40 national public health, medical, nursing and  
 31 health care organizations engaged in healthy air advocacy efforts.<sup>13</sup> The Coalition is united  
 32 in its calling for strong federal laws and policies to slash air pollution and address climate  
 33 change, recognizing climate change can affect air quality, and certain air pollutants can  
 34 affect climate change. The AMA also became a member of the newly formed Alliance for  
 35 Heat Resilience and Health, which includes over a dozen national organizations working in  
 36 collaboration to advance protective standards, proactive emergency plans, and local and  
 37 state-based engagement around extreme heat.
- 38 • In terms of advocacy efforts, the AMA joined with partners or submitted comments  
 39 separately on the following:
  - 40 • On February 4, 2026, the AMA joined 19 medical and health organizations in a [letter](#)  
 41 opposing the National Highway Traffic Safety Administration’s proposed weakening  
 42 of fuel efficiency standards for vehicles and light trucks.
  - 43 • On September 22, 2025, the AMA joined 120+ medical and health organizations in a  
 44 [letter](#) opposing the EPA's proposed repeal of the 2009 Greenhouse Gas Endangerment  
 45 Finding and Greenhouse Gas Vehicle Standards.
    - 46 ○ The AMA provided [testimony](#) to the EPA affirming the importance of the  
 47 Greenhouse Gas Endangerment finding and noting the public health impacts of  
 48 climate change.
  - 49 • On August 7, 2025, [sent](#) a letter opposing the EPA's proposed rule to repeal  
 50 Greenhouse Gas Emissions Standards for Fossil Fuel-Fired Electric Generating Units.

1 ***B. Prevent firearm injuries and deaths.***  
 2

3 In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are  
 4 one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual  
 5 Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence  
 6 represents a public health crisis which requires a comprehensive public health response and  
 7 solution." Since that time firearm injuries and deaths have increased, and disparities have  
 8 widened.<sup>15</sup>  
 9

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

26  
 27 Agree to Agree. The AMA is collaborating with the Ad Council on the [Agree to Agree](#) initiative,  
 28 which is focused on finding common ground to reduce the impact of firearm violence on children  
 29 and teens across all communities in the U.S. This campaign launched in early 2025 and is focused  
 30 on reaching distinct audiences, including parents and those with children in their lives who have a  
 31 vested interest in protecting our youth and health care professionals who witness the impact of  
 32 firearm violence firsthand. The initiative will expand to provide additional resources and tools to  
 33 reach specific audiences and communities with the goal of addressing all forms of firearm violence  
 34 as part of our comprehensive approach to combating this complex crisis. “Agree to disagree” is a  
 35 phrase that ends a conversation, the goal of this campaign is to start a conversation.  
 36

- 37 • On Thursday, March 6, 2025, AMA participated in a [Washington Post Live conversation](#)  
 38 about how gun violence has impacted communities around the country, initiatives to find  
 39 common ground, and efforts to bolster public safety and health.
- 40 • On October 23, 2025, the Ad Council in partnership with the American Medical  
 41 Association, through the work of the task force and a coalition of health care and business  
 42 leaders, launched new firearm injury prevention creative and an expanded digital resource  
 43 hub for health care professionals at [AgreeToAgree.org/Healthcare](#). The resource hub  
 44 provides links to educational materials to support physicians having effective  
 45 conversations about firearm injury prevention with patients, parents, other health care  
 46 professionals and community members.
- 47 • In the first year of the Agree to Agree campaign, it has:
  - 48 ○ Received 35.4 million in total donated media resulting in 2.4 billion impressions.
  - 49 ○ Reached 69.5 percent of the audience in first 4 months of campaign launch,  
 50 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.

- 1                   ○ In 2025, the AMA developed and disseminated physician education, “[Safer](#)  
2                    [Prescribing of Opioids for Pain Management: Bridging Guidelines and Practice](#)  
3                    [Through Interactive Learning](#)” to support physician’s improving their opioid  
4                    prescribing. This education received two Brandon Hall Group Educational  
5                    Awards for Leaders in Education Technology – Best E-learning, Blended, Flipped  
6                    Classroom Solution and Learning and Development Technology Award – Best  
7                    Advance in Education Delivered Through Technology.  
8                    ○ In 2025, the AMA developed additional episodes of the physician education  
9                    podcast series on “[The Opioid Overdose Epidemic](#).” Podcast episodes feature  
10                  experts who shared relevant research, insights, and experience to help physicians  
11                  of all specialties in addressing the opioid overdose epidemic. In 2025, podcast  
12                  engagement included 26,757 downloads, with a high interest in the following  
13                  topics: “Opioid Prescribing and Appropriate Pain Management,”” Opioid  
14                  Overdose Prevention,” and “Opioid Use Disorder Treatment.”  
15                  ○ In the past year, the AMA supported the content for the physician education series  
16                  module “[Practical Guidance for Pain Management](#).” This content was made  
17                  available to help physicians meet the DEA’s MATE Act requirements, effective as  
18                  of June 27, 2023.
- 19                  ● The AMA continues to convene the Substance Use and Pain Care Task Force, which  
20                  supports and guides the development of the annual [Overdose Epidemic Report](#) on the  
21                  overdose epidemic outlining current data, policy, updates, clinical accomplishments and  
22                  what still needs to be done.<sup>21</sup> This group meets on a quarterly basis throughout the year to  
23                  engage with stakeholders and experts with emerging barriers, challenges and development  
24                  of solutions
  - 25                  ● The AMA is also a member of the [Providers Clinical Support System](#) (PCSS), which is  
26                  made up of a coalition of major health care organizations all dedicated to addressing this  
27                  health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS  
28                  provides evidence-based training and resources to give health care providers the skills and  
29                  knowledge they need to treat patients with opioid use disorders and chronic pain.<sup>20</sup>
  - 30                  ● The AMA is a sponsor of the [National Academy of Medicine, Action Collaborative on](#)  
31                  [Combatting Substance and Opioid Crises](#). The Action Collaborative is committed to  
32                  proactively driving structural change by developing, curating, and implementing multi-  
33                  sector solutions designed to reduce substance misuse and improve outcomes for  
34                  individuals, families, and communities affected by addiction.
  - 35                  ● The AMA was awarded funding from the CDC in 2024 and continued work to develop and  
36                  implement a clinician toolkit focused on the recommendations and guiding principles of  
37                  the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically  
38                  tailored to community health centers (CHCs). During the two-year project period, the  
39                  AMA will partner with the National Association of Community Health Centers to develop  
40                  an actionable toolkit resource for clinicians and will implement the toolkit resource in  
41                  CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational  
42                  experience for clinicians working in CHCs that is unique and sensitive to the needs of  
43                  CHCs while also preparing them to serve as content experts and agents of change for their  
44                  local healthcare communities regarding pain care.
  - 45                  ● The AMA continues to be a data resource for stakeholders, policymakers, clinicians, and  
46                  researchers with its “[End The Epidemic](#)” website and data dashboard. This website  
47                  maintains up to date resources for stakeholders to utilize and an interactive data dashboard  
48                  to highlight regional differences and trends of the drug overdose epidemic.
  - 49                  ● The AMA released its [2025 Substance Use and Treatment: Progress, Policy and Future](#)  
50                  [Directions Report](#) showing increases in polysubstance use, naloxone access for life-saving

1 intervention, and policy promoting evidence-based care but underscoring ongoing  
2 challenges as the nation's drug overdose epidemic continues.

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

6  
7 The AMA is collaborating with leading health care organizations to strengthen the interface  
8 between public health and health care. In November 2023, AMA and health care partners  
9 announced the Common Health Coalition: Together for Public Health, a partnership between AMA  
10 and four other leading healthcare organizations, including: AHIP (formerly America's Health  
11 Insurance Plans), Alliance of Community Health Plans, American Hospital Association, and  
12 Kaiser Permanente.<sup>22</sup> The Common Health Coalition is focused on translating the hard-won lessons  
13 and successes of the COVID-19 pandemic response into actionable strategies that will strengthen  
14 the partnership between our health care and public health systems.

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

28  
29 In addition, the AMA took the following actions:

- 30  
31 • On August 1, 2025, the AMA issued a [leadership viewpoint](#) noting that slashing the  
32 National Institutes of health funding imperils the foundation of medical research, which  
33 has played a critical role in improving the nation's health.
- 34 • On August 28, 2025, the AMA issued a [press statement](#) noting that the removal of CDC  
35 Director Susan Monarez and the resignations of other senior CDC leaders are highly  
36 alarming at a challenging moment for public health. In the wake of CDC budget cuts and  
37 the termination of hundreds of employees earlier this year, the AMA is deeply concerned  
38 that this turmoil leaves us highly susceptible to public health threats.

39  
40 **4. Combat the spread of misinformation and disinformation.**

41  
42 The AMA remains engaged in external collaborations to address mis- and disinformation, such as  
43 the Coalition for Trust in Health & Science.

- 44  
45 • The [Coalition for Trust in Health and Science's](#) vision is for all people to have equitable  
46 access to accurate, understandable, and relevant information to make personally  
47 appropriate health choices and decisions. The AMA is an active member, engaging with  
48 leadership and participating in programming.

- 1       • The AMA was an active participant in the [Mitigating Medical Misinformation Workgroup](#),  
2 but that group has decided to meet less frequently and incorporate its work into the broader  
3 Coalition for Trust in Health & Science.
- 4       • On March 5, 2026, the AMA issued a statement on the new [survey findings](#) from the  
5 Annenberg Public Policy Center, which highlight a widening trust gap in the nation's  
6 health information landscape and underscore the importance of trusted medical voices  
7 grounded in science. The survey found that physicians and medical organizations remain  
8 among the most trusted sources of public health information, with about 73 percent of  
9 Americans expressing confidence in the American Medical Association (AMA). Overall,  
10 by a two-to-one margin, those polled said they would accept AMA's recommendations (35  
11 percent) over the CDC's (16 percent) if the two bodies issued conflicting statements on  
12 vaccine safety. The findings come at a time when confidence in federal health agencies has  
13 unfortunately declined, even as Americans continue to rely heavily on physicians and  
14 medical experts for credible, evidence-based information about health and disease  
15 prevention.

16  
17 The AMA will continue to evaluate opportunities to work with the Ad Council and other health-  
18 related organizations on future evidence-based public information campaigns.

19  
20 CONCLUSION

21  
22 The current political environment has elevated the critical importance of AMA's role of promoting  
23 and disseminating evidence-based public health policy and content. The AMA continues to  
24 advance its mission, to promote the art and science of medicine and the betterment of public health.  
25 The highlighted accomplishments in this report capture a fraction of the work accomplished from  
26 March of 2025 – March of 2026 related to the AMA's public health strategy. The AMA will  
27 continue to engage on these critical issues to maintain the organization as a trusted source of  
28 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

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

4  
5 A report on the demographics of our AMA House of Delegates will be issued annually and  
6 include information regarding age, gender, race/ethnicity, education, life stage, present  
7 employment, and self-designated specialty.

8  
9 In addition, this report includes information pursuant to Policy G-635.125, “AMA Membership  
10 Demographics,” which states:

11  
12 Stratified demographics of our AMA membership will be reported annually and include  
13 information regarding age, gender, race/ethnicity, education, life stage, present employment,  
14 and self-designated specialty.

15  
16 This document compares the House of Delegates (HOD) with the entire American Medical  
17 Association (AMA) membership and with the overall United States physician and medical student  
18 population. Medical students are included in all references to the total physician population  
19 throughout this report to remain consistent with the bi-annual Council on Long Range Planning and  
20 Development report. In addition, residents and fellows endorsed by their states to serve as sectional  
21 delegates and alternate delegates are included in the appropriate comparisons for the state and  
22 specialty societies. For the purposes of this report, AMA-HOD includes both delegates and  
23 alternate delegates.

24  
25 DATA SOURCES

26  
27 Lists of delegates and alternate delegates are maintained in the Office of House of Delegates  
28 Affairs and are based on official rosters provided by the relevant society. The lists used in this  
29 report reflect 2025 year-end delegation rosters.

30  
31 Data on individual demographic characteristics are taken from the AMA Physician Professional  
32 Data, which provides comprehensive demographic, medical education, and other information on all  
33 United States and international medical graduates (IMGs) who have undertaken residency training  
34 in the United States. Data on AMA membership and the total physician and medical student  
35 population are taken from the Masterfile and are based on 2025 year-end information.

36  
37 Some key considerations must be kept in mind regarding the information captured in this report.  
38 Vacancies in delegation rosters mean that the total number of delegates credentialed for the  
39 November 2025 Interim Meeting is less than the 733 allocated and the number of alternate  
40 delegates credentialed is nearly always less than the full allocation. As such, the total number of

1 delegates and alternate delegates credentialed for the 2025 Interim Meeting is 1186 rather than the  
 2 1466 allotted. Race and ethnicity information, which is provided directly by physicians, is missing  
 3 for approximately 10 percent of AMA members and approximately 22 percent of the total United  
 4 States physician and medical student population, limiting the ability to draw firm conclusions.  
 5 Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements  
 6 have been made in collecting data on race and ethnicity, resulting in a decline in reporting  
 7 race/ethnicity as unknown in the HOD and the overall AMA membership.

8  
 9 **CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES**

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

12  
 13  
 14 Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as  
 15 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
<b>Age distribution</b>			
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%
<b>Gender</b>			
Male	57.23%	60.74%	57.59%
Female	41.98%	38.57%	42.24%
Unknown	0.79%	0.69%	0.17%
<b>Race/ethnicity</b>			
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%
<b>Education</b>			
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)
<b>Life Stage</b>			
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%
<b>Present Employment</b>			
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%
<b>Specialty</b>			
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

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

5  
6 The policy affirms the AMA’s support for private practice, recognizes its importance to physician  
7 autonomy and professional sustainability, and acknowledges the value independent practices  
8 provide to patients and communities.

9  
10 This report details AMA activities since the 2024 Annual Meeting to preserve and strengthen  
11 independent medical practice. It reflects both the governance structures established to ensure  
12 durable representation of independent physicians within the AMA and the specific policy,  
13 advocacy, and programmatic outcomes advanced through those structures.

## 14 15 DISCUSSION

16  
17 During this reporting period, AMA’s support for independent medical practice has focused on three  
18 interrelated areas of work:

- 19
- 20 • ensuring independent physicians have an organized, durable voice in AMA policy
  - 21 development;
  - 22 • creating consistent, direct engagement channels through which independent physicians can
  - 23 surface operational challenges and share practice-level strategies; and
  - 24 • delivering tools, education, structured advocacy, and practice resources that address the
  - 25 day-to-day realities of operating an independent practice.
- 26

### 27 *Providing a voice for independent physicians in AMA policy development*

28  
29 The Private Practice Physicians Section (PPPS) remains the primary mechanism through which  
30 independent physicians engage in the AMA policymaking process. Established by action of the  
31 HOD in 2020 and operational since 2021, the Section functions as a stable governance unit with  
32 defined leadership roles, regular business meetings, and repeatable policy workflows aligned with  
33 the HOD policymaking cycle.

34  
35 As of March 2026, PPPS includes approximately 425 certified members representing a broad range  
36 of specialties, practice sizes, and geographic regions. Continued membership growth reflects  
37 sustained demand for a forum focused on the policy and operational concerns of independent  
38 physicians.

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

- 3
- 4 • surface practice-level issues identified by members;
  - 5 • review emerging regulatory, payer, and market developments affecting independent  
6 practices;
  - 7 • draft and refine policy proposals; and
  - 8 • coordinate Section positions on HOD items of business.
- 9

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

- 14
- 15 • Resolution 229-I-24, Supporting Penalties on Insurers Who Fail to Pay Doctors, directed  
16 the AMA to advocate for penalties against insurers that fail to pay physicians within  
17 required timeframes after physicians prevail in the federal Independent Dispute Resolution  
18 process, addressing delayed payment practices that create financial strain for independent  
19 practices.
  - 20 • Resolution 714-A-25, Root Cause Analysis of the Causes of the Decline of Private Medical  
21 Practice, directed the AMA to conduct a comprehensive analysis of the economic,  
22 regulatory, educational, and market forces contributing to the decline of private practice,  
23 formally committing the AMA to evidence-based examination of consolidation and  
24 practice closure trends.
  - 25 • Resolution 715-A-25, Grace Period for Timely Filing Due to Technology Failures  
26 Regardless of Cause, directed the AMA to advocate for relief from timely filing limits  
27 when claims processing failures occur due to large-scale technology disruptions, protecting  
28 practices from denials caused by circumstances beyond physician control.
  - 29 • Resolution 810-I-25, Opposing Unilateral Downcoding of Physician Services by Insurance  
30 Companies, directed the AMA to oppose insurer-initiated downcoding of evaluation and  
31 management services, reaffirm CPT® and E/M guidelines as the national standard, and  
32 pursue regulatory, legislative, educational, and, where appropriate, legal strategies to  
33 address such practices.
- 34

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

37  
38 *Outreach and engagement with independent physicians*

39  
40 Beyond formal HOD activity, PPS convenes recurring engagement forums intentionally aligned  
41 with the HOD policymaking cycle to support timely policy development and review.

42  
43 Each year, the Section hosts two primary engagement events:

- 44
- 45 • a spring virtual Town Hall meeting aligned with preparations for the AMA Annual  
46 Meeting; and
  - 47 • a fall engagement and policy discussion aligned with the AMA Interim Meeting.

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

6  
7 Issues surfaced through these engagement forums are carried forward into PPPS business meetings,  
8 translated into policy proposals where appropriate, and used to shape educational programming and  
9 resource referrals. Additionally, PPPS is developing member committees focused on practice  
10 sustainability and advocacy to extend engagement between meetings and provide additional  
11 opportunities for member input and collaboration.

12  
13 *Advocacy in support of independent practice*

14  
15 In parallel with PPPS contributions to AMA policy development and practice support initiatives,  
16 the AMA has continued to engage in advocacy actions that directly affect independent physicians.  
17 Prime examples of these efforts include:

- 18 • Fixing our nation's unsustainable Medicare payment system will remain a top AMA  
19 advocacy priority until meaningful reform is achieved. Physicians are urged to join the  
20 fight for reform by visiting [FixMedicareNow.org](https://www.fixmedicarenow.org) which coordinates grassroots action on  
21 AMA priority Medicare Payment Reform bills. The campaign has generated more than 103  
22 million earned media and ad impressions, 3.9+ million media and ad engagements, and  
23 100,000+ contacts to Congress, as well as a combined 235+ third-party media placements  
24 and grassroots contacts made in key Congressional districts in 2025 alone.
- 25 • AMA submitted comment letters to the Centers for Medicare & Medicaid Services on the  
26 CY 2025 Medicare Physician Fee Schedule Proposed Rule and the CY 2026 Medicare  
27 Physician Fee Schedule Proposed Rule, addressing physician payment adequacy, proposed  
28 conversion factor reductions, and administrative burden associated with Medicare  
29 participation.
- 30 • AMA engaged in federal advocacy related to prior authorization reform, including  
31 physician-facing implementation issues arising from the CMS Interoperability and Prior  
32 Authorization Final Rule (CMS-0057-F). Advocacy focused on prior authorization  
33 timelines, transparency requirements, and payer compliance obligations with implications  
34 for independent practice operations. Further AMA advocacy to reform prior authorization  
35 includes supporting federal legislation; collaborating with influential policy organizations  
36 such as the National Conference of Insurance Legislators and the National Association of  
37 Insurance Commissioners; and partnering with patient advocacy groups to advance key  
38 measures. The AMA also provided testimony and influenced recommendations from an  
39 advisory council convened by the Department of Labor to consider regulatory changes to  
40 how employer-sponsored health plans governed by ERISA use prior authorization and  
41 manage claims and appeals procedures. AMA also worked closely with over 20 states that  
42 enacted prior authorization reform legislation in 2025.
- 43 • Following the February 2024 Change Healthcare cyber-event, the AMA issued public  
44 statements and advocacy communications and engaged with federal agencies and payers  
45 regarding widespread claims processing disruptions, timely filing requirements, and  
46 payment relief for affected physician practices. These efforts sought to mitigate financial  
47 harm to independent practices caused by large-scale system failures beyond physician  
48 control.
- 49 • AMA has advocated for fair contracting and out-of-network payments including engaging  
50 in litigation to force implementation of the No Surprises Act (NSA) as Congress intended,  
51 advocating to regulators and Congress to ensure independent dispute resolution awards  
52 under the NSA are paid, and in the required timely manner, by insurers to physicians, and

1           sounding the alarms on health insurer practices that bypass the NSA and threaten the  
2           sustainability of independent practices. AMA has also supported the No Surprises Act  
3           Enforcement Act in the [House](#) and [Senate](#).

- 4           • The AMA has continued federal and state legislative advocacy on insurer administrative  
5           practices, and accountability measures including releasing a state model bill on insurer  
6           downcoding practices, physician-led team-based care, physician wellness, advancing  
7           technology including augmented intelligence, access to care, and medical liability  
8           consistent with adopted House of Delegates policy. In addition, AMA has participated in  
9           legal advocacy, including amicus curiae activity, in matters affecting physician  
10          reimbursement and practice viability.

11  
12          Collectively, these advocacy efforts reflect the execution of AMA policy positions through  
13          regulatory, legislative, communication, and legal channels that shape the operating environment for  
14          independent medical practices.

15  
16          *Promoting resources for the advancement of independent practice*

17  
18          The AMA has continued to invest in practical resources designed to support the operational and  
19          financial sustainability of independent medical practices.

20  
21          The AMA STEPS Forward® initiative remains a central platform for this work, offering open-  
22          access, practice-focused tools through the AMA Ed Hub™. These resources include  
23          implementation guides, templates, webinars, podcasts, and continuing medical education  
24          opportunities addressing staffing, workflow design, regulatory compliance, patient engagement,  
25          and practice operations. Independent practice-specific offerings include the 7 STEPS to Starting a  
26          Private Practice guide and the [Private Practice Playbook](#), which provides adaptable templates such  
27          as patient intake forms, administrative policies, and employee documentation.

28  
29          Building on these resources, in 2025 the AMA launched the Independent Practice Incubator  
30          through the STEPS Forward® Innovation Academy. The incubator is a structured, cohort-based  
31          program designed for physicians planning to establish office-based, physician-owned independent  
32          practices. The program integrates asynchronous learning, live virtual sessions with subject-matter  
33          experts, and peer collaboration, covering business planning, legal and regulatory considerations,  
34          credentialing and contracting, staffing and human resources, revenue fundamentals, and patient  
35          acquisition and retention. The incubator spanned approximately 12 months and culminated in the  
36          development of a comprehensive business proposal, providing participants with a structured  
37          pathway from early concept through implementation readiness. Learning and content from the  
38          incubator will inform more structured, more widely available AMA Private Practice Accelerator  
39          events in the future.

40  
41          PPPS also uses its Annual and Interim Meeting convenings to provide issue-focused education and  
42          operational peer exchange. Programming is member-informed and aligned with the same pipeline  
43          that drives PPPS policy development, ensuring that issues raised by members translate into both  
44          policy action and practical guidance supported by existing AMA resources.

45  
46          Finally, the AMA has published a curated collection of education modules, “[Thriving in Private](#)  
47          [Practice](#),” to help physicians effectively build and manage a private medical practice. The  
48          collection includes 7.5 hours of learning content on topics including payer contracting and audits,  
49          human resources, marketing and branding, and revenue cycle management.

1 CONCLUSION

2

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

6

7 Through durable representation in the AMA policymaking process, measurable policy outcomes  
8 driven by independent physicians, documented regulatory, legislative, and legal advocacy,  
9 recurring engagement aligned with the AMA meeting cycle, and sustained investment in practical  
10 tools and programs, the AMA has continued to provide tangible support for independent medical  
11 practice. These efforts establish a strong foundation for continued work to ensure that independent  
12 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

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1 At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates  
2 (HOD) adopted Policy D-300.971, “Upholding Professional Integrity and Ethical Leadership,”  
3 which states the following:

- 4  
5 1. Our American Medical Association is committed to sustaining accessible, physician-led  
6 education and discourse on the ethical challenges in medicine.  
7
- 8 2. Our AMA will develop and publicize opportunities for medical ethics engagement and  
9 learning across the association.  
10
- 11 3. Our AMA will continue to advance and fund opportunities for editorial fellowships in  
12 ethics for trainees and early-career physicians commensurate to the AMA Journal of Ethics  
13 Editorial Fellowship.  
14
- 15 4. Our AMA will report back on its progress and advancement for medical ethics engagement  
16 and editorial fellowships for trainees and early-career physicians at Annual 2026.  
17

18 This report is submitted as information to the House of Delegates about a new ethics opportunity at  
19 the AMA.  
20

21 NEW ETHICS FELLOWSHIP  
22

23 Building on the *AMA Journal of Ethics*’ record of engagement with the next generation of  
24 physicians, a new ethics fellowship, crafted to retain key elements that were valued by past journal  
25 editorial fellows, was recently launched. Key aspects of the new fellowship program are as follows:  
26

- 27 • Every April, a “Call for Ethics Fellows,” seeking applications from medical students,  
28 resident physicians, and fellows in U.S.-based accredited MD or DO programs, will be  
29 posted and promoted through AMA membership and communication channels.  
30
- 31 • Fellowship applications will propose a timely and important medical ethics topic and how  
32 it can be explored through a multimedia approach such as video or podcast.  
33
- 34 • Fellows will also secure a faculty mentor who will work along with AMA Ethics staff to  
35 help them conceptualize the topic, refine questions to be addressed, and identify experts to  
36 be featured. It is worth noting that this opportunity to collaborate with subject matter  
37 experts in their home institution (and the AMA) was routinely highlighted in Dean’s letters

1 of previous journal editorial fellows and became an insightful point of conversation during  
2 medical students' residency interviews.

3  
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14

- 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

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1 At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, Reimbursement  
2 of Necessary Business Meeting Expenses for Delegates and Alternates. This informational report  
3 responds to the first directive of the policy:  
4

- 5 1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and  
6 each meeting thereafter, identifying the number of delegates and alternate delegates  
7 supported by the grants and the total amount provided under our AMA House of Delegates  
8 Emergency Assistance Program (HOD EAP).  
9

10 In 2025, AMA received requests from 21 societies to participate in the HOD EAP program. Three  
11 societies did not meet the criteria outlined in the policy adopted by the House. The EAP awarded  
12 grants to the remaining 18 federation societies.  
13

14 Each qualifying society was required to submit a grant funding request form for each of the 2025  
15 Annual and Interim Meetings indicating the number of delegates and alternates, regional medical  
16 student delegates and sectional resident and fellow delegates to be funded for each organization.  
17 Fifty percent of the requested amount was paid prior to the meeting with the remainder paid out  
18 based on verified actual attendance following the meeting.  
19

20 For example, if a qualifying association had requested grant funding for four delegates and four  
21 alternates, two regional medical student delegates and one sectional resident delegate, that society  
22 would be eligible for grant money for 11 attendees or \$16,500. The initial payment would have  
23 been calculated and paid at 50 percent of the requested amount or \$8,250. Assuming only nine of  
24 those included in the initial request attended the meeting, the total grant would be recalculated at  
25 \$1,500 times nine attendees or \$13,500 and the final payment would be the difference between the  
26 recalculated grant amount and the first installment payment or \$5,250. This was to ensure that grant  
27 funding is used solely for actual delegates and alternate delegates attending the meeting.  
28

29 Based on grant funding requests, a total of \$420,000 was made available for the 2025 Annual  
30 Meeting and 50 percent or \$210,000 was paid to societies in advance of the meeting. After  
31 verification of actual attendance, a total number of delegates and alternate delegates attending the  
32 meeting from the 18 approved societies was 246, including 14 sectional residents and 16 regional  
33 students and the grant amounts paid for the Annual Meeting totaled \$368,400.  
34

35 For the November 2025 Interim Meeting, a total of \$331,200 was made available and 50 percent or  
36 \$165,600 was paid to societies in advance of the Interim Meeting. After the verification of actual  
37 attendance, the total number of delegates and alternate delegates attending the meeting was 243,  
38 including 13 sectional resident/fellows and 18 regional students and the total grant amounts paid  
39 for the Interim Meeting was \$285,100. It should be noted that total funding for an organization was

1 capped at \$100,000 for the year and final payments were adjusted so that no society exceeded this  
2 cap.

3

4 In 2026, AMA received 24 requests to participate in the EAP program. Three organizations did not  
5 meet the criteria for the program. The EAP program will award grants to the remaining 21  
6 federation societies which may potentially fund up to \$872,200 for 315 delegates and alternates, 22  
7 regional medical students and 15 sectional resident and fellow delegates and alternates for both the  
8 Annual and Interim Meetings. Funding requests are currently in process for the 2026 Annual  
9 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

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1 At the 2025 AMA Annual Meeting, the House of Delegates (HOD) adopted Policy D-615.976,  
2 “Advisory Committee on Tribal Affairs,” which directs the AMA to:

3  
4 Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a  
5 Task Force on Tribal Affairs composed of AMA members who themselves identify as  
6 American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN  
7 communities (e.g., members of Association of Native American Medical Students and  
8 Association of American Indian Physicians), or have direct experience working with AI/AN  
9 communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban  
10 Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy  
11 specific to AI/AN communities and that the Task Force report back at the 2026 Annual  
12 Meeting with recommendations for the establishment of an Advisory Committee to ensure  
13 sustained attention to tribal health equity and Indigenous physician representation.

14  
15 Our AMA will promote and foster educational opportunities for AMA members and the  
16 medical community to better understand the contributions of AI/AN communities to medicine  
17 and public health, including cultivating a rich understanding and appreciation of AI/AN  
18 perspectives on health and wellness.“  
19

20 At the 2025 AMA Interim Meeting, the Board of Trustees presented an informational report, BOT  
21 Report 17, indicating that that Board was taking the necessary steps to form an Advisory  
22 Committee on American Indian and Alaska Native (AI/AN) Affairs and would report back at the  
23 2026 Annual Meeting. This follow-up report is informational.  
24

25 At its November 2025 meeting, the Board approved a charter for a new Advisory Committee on  
26 AI/AN Affairs. Under this charter, the Advisory Committee will advise the Board and AMA  
27 management on policy and advocacy matters pertaining to AI/AN medical students, physicians,  
28 and patients, and otherwise contribute to AMA initiatives related to this population.  
29

30 The charter creates a seven-member Advisory Committee composed of:

- 31 • One medical student member,
- 32 • One resident or fellow member,
- 33 • One young physician member,
- 34 • Three physician members at-large (non-medical student/resident/fellow), and
- 35 • One physician representative of the Association of American Indian Physicians ( non-  
36 medical student/resident/fellow).

- 1 Advisory Committee members are appointed by the Board, prioritizing candidates who:  
2     • Have close professional relationships with AI/AN communities; and/or  
3     • Have direct experience working with AI/AN communities through Indian Health Service  
4 programs, tribally operated programs, Urban Indian Health Programs, or other programs  
5 serving AI/AN communities.  
6

7 The Board appointed the following members to the inaugural Advisory Committee, which will  
8 convene for the first time in conjunction with the 2026 AMA Annual Meeting:

- 9     • Medical student member: Mateo Perez  
10    • Resident/fellow member: William Swain, MD  
11    • Young physician member: Hannah Catherine Wenger, MD  
12    • Member at-large: Janice Heaton-Sheufelt, MD (Vice Chair)  
13    • Member at-large: Donald Warne, MD  
14    • Member at-large: Siobhan Wescott, MD (Chair)  
15    • 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

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1 At the 2021 Interim Meeting of the American Medical Association (AMA) House of Delegates  
2 (HOD) BOT Report 19-I-21, “Advocacy for Physicians and Medical Students with Disabilities,”  
3 was adopted.

4  
5 The policy states: Our AMA will: (1) establish an advisory group composed of AMA members  
6 who themselves have a disability to ensure additional opportunities for including physicians and  
7 medical students with disabilities in all AMA activities; (2) promote and foster educational and  
8 training opportunities for AMA members and the medical community at large to better understand  
9 the role disabilities can play in the healthcare work environment, including cultivating a rich  
10 understanding of so-called invisible disabilities for which accommodations may not be  
11 immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate  
12 for themselves in their own workplaces, including a deeper understanding of the legal options  
13 available to physicians and medical students to manage their own disability-related needs in the  
14 workplace; and (4) communicate to employers and medical staff leaders the importance of  
15 including within personnel policies and medical staff bylaws protections and reasonable  
16 accommodations for physicians and medical students with visible and invisible disabilities.

17  
18 This informational report provides the progress of the advisory group.

19  
20 The Disability Advisory Group (DAG) has provided strategic guidance, subject matter expertise,  
21 and community outreach to ensure AMA policies and initiatives meaningfully address the needs of  
22 physicians, trainees, and patients with disabilities. The group currently includes 12 members with  
23 diverse representations, including disability type, career stage, and other identity factors—and  
24 incorporates input from external subject matter experts. The DAG has two active workgroups, one  
25 focused on education related to disability in medicine, and a second focused on strengthening  
26 accommodations in workplaces, educational institutions, and AMA meetings for physicians,  
27 trainees, and students with disabilities. With regular meetings and communication to the BOT  
28 through the two Board liaisons and other mechanisms, the DAG operates collaboratively to inform  
29 AMA efforts, always aligned with the organization’s broader mission of supporting physicians and  
30 students, and optimizing health outcomes for all patients.

31  
32 Current estimates suggest people with disabilities (PWD) are underrepresented in the physician  
33 workforce, with only 4.6 percent of medical students<sup>1</sup> and 3.1 percent of physicians<sup>2</sup> reporting a  
34 disability, compared to an estimated 26.7 percent of the adult U.S. population in 2022.<sup>3</sup> Federal law  
35 (the Americans with Disabilities Act<sup>4</sup>) requires public entities and employers to provide equal  
36 access and accommodations for PWD, ensuring non-discrimination and accessibility in services,  
37 programs, facilities, and employment opportunities. Data is not yet available regarding the  
38 prevalence of disability among AMA members; however, members of the DAG identified  
39 challenges to fully participating in AMA meetings due to unmet accessibility needs.

40  
41 In addition to accessibility challenges, knowledge gaps regarding disability are shaped by the way  
42 disability is taught in medical education. Because training often emphasizes the medical model

1 (framing disability primarily as a health problem to be solved),<sup>5</sup> health care professionals' attitudes  
2 and practices may overlook other important factors. The biopsychosocial model of disability  
3 considers not only medical aspects, but also personal, social, environmental, and cultural contexts,  
4 offering a more complete understanding of disability.<sup>6</sup> This more expansive approach to disability  
5 is also supported by the World Health Organization.<sup>7</sup> Given this, the DAG identified the need to  
6 create additional educational resources for medical students and physicians to address ableism in  
7 medical training and improve quality of care for PWD.

8  
9 DISCUSSION

10  
11 2024-2025 ACCOMPLISHMENTS

12  
13 In its first 18 months, the DAG collaborated with AMA staff, Board members, and aligned  
14 organizations (e.g., the Association of American Medical Colleges (AAMC) and the Docs With  
15 Disabilities Initiative (DWDI) to create educational content as well as operational and policy  
16 recommendations to improve disability inclusion in medicine and optimize health outcomes for  
17 people with disabilities (PWD).

18  
19 *Workplace Inclusion Workgroup*

20  
21 The Workplace Inclusion Workgroup reflected on gaps in accommodations for PWD experienced at  
22 past HOD meetings, and suggested changes to improve access for physicians and staff with diverse  
23 needs. Members of the working group collaborated closely with the staff to enact some of these  
24 changes in 2025.

25  
26 Numerous strategies to improve access for physicians and others with disabilities were undertaken.  
27 For example, power strips were made accessible through the end of HOD meetings to ensure PWD  
28 can charge communication and mobility equipment as needed. The physical layouts of meeting  
29 venues were reviewed and adjusted to better accommodate wheelchairs; at the 2025 Annual and  
30 Interim meetings, for example, ramps were added to ensure access to all podiums. Specific areas  
31 for wheelchair users were also marked in reference committee meetings to ensure access, and  
32 microphone placements were reviewed and adjusted to allow wheelchair users and others with  
33 limited mobility to access them. Pressure sensors were added in front of microphones to  
34 communicate when someone approaches; this ensures Speakers are aware of all individuals waiting  
35 to speak, including PWD who may not be as easily seen as non-disabled physicians (e.g., when  
36 using a wheelchair). In addition to improving physical access at meetings, virtual spaces and digital  
37 content were reviewed and adjusted. For example, the font size and text color in presentations were  
38 updated to meet current web content accessibility guidelines, improving access for people with  
39 visual disabilities. Based on input from the DAG, the Meeting Services team supported the addition  
40 of live captioning and American Sign Language interpreters for 2025 meetings. There has been  
41 improvement in data collection and feedback regarding experiences of PWD as HOD attendees;  
42 however, this is currently collected in an ad hoc manner. Feedback mechanisms could be  
43 formalized for future meetings.

44  
45 *Education Workgroup*

46  
47 A dedicated education workgroup has advanced several initiatives to improve disability inclusion  
48 in medicine, both for physicians with disabilities and in providing better care for patients with  
49 disabilities. Informed by input from members of the DAG, expert interviews, and collaboration  
50 with key external organizations, staff is developing and platforming foundational educational

1 modules to address gaps in physician education around ableism in health care. These resources aim  
2 to help learners identify ableism, understand its impact, and foster more equitable health outcomes  
3 for PWD.  
4

5 The DAG members contributed to designing multiple live educational events, including at the  
6 HOD Annual meeting in 2024 (recording platformed as enduring educational content [here](#)) and a  
7 panel discussion on disability inclusion in medical education at the 2025 Interim HOD meeting,  
8 both of which offer free CME. An interactive foundational module, “Disability Inclusion:  
9 Addressing Ableism in Medical Education and Health Care” was built in close collaboration with  
10 the DAG and published on EdHub in late 2025.<sup>8</sup>  
11

## 12 2026 PRIORITIES

13  
14 In 2026 and beyond, staff will continue the work initiated by the DAG. The DAG has identified  
15 opportunities to collaborate with other organizations (e.g., AAMC) to address challenges, e.g., the  
16 revision of technical standards that may inadvertently exclude students with disabilities from  
17 participating in medical education and training. Opportunities remain to review and suggest  
18 improvements to AMA policy and procedures as the Board considers how to address ableism in  
19 organizational policies and practices.  
20

### 21 *Workplace Inclusion Workgroup*

22  
23 While much has been accomplished with input from the DAG, work remains to ensure that AMA  
24 meeting spaces are inclusive of PWD. In 2026, the DAG Workplace Inclusion Workgroup will  
25 continue to collaborate with staff to improve accessibility and inclusion at AMA meetings,  
26 particularly the Annual meetings in Chicago. Key areas of exploration and focus will include:  
27 increasing time between sessions for PWD to move between rooms; creating a mechanism to signal  
28 that someone needs more time to reach a microphone before giving testimony; and involving DAG  
29 members or other PWD in 1) pre-meeting planning, 2) on-site accessibility assessments in hotels,  
30 and 3) venue selection for future sites. The workgroup will also continue to work to suggest  
31 feasible support for accommodating service animals and personal care assistants and propose  
32 funding mechanisms to support PWD attendees. They will continue to work with the Council on  
33 Long Range Planning and Development (CLRPD) to identify strategies through which the AMA  
34 can better understand the prevalence of disability and accommodation needs among HOD attendees  
35 and AMA members more broadly. Lastly, the workgroup aims to develop and share a model  
36 accessibility guide, with suggested operational improvements for varied workplace and educational  
37 settings.  
38

### 39 *Education Workgroup*

40  
41 Additional educational projects underway for 2026 publication include content to increase  
42 disability inclusion and improve care for PWD. Interactive modules to ensure a more inclusive  
43 environment for students and physicians with disabilities are being created in collaboration with the  
44 DWDI, focusing on addressing ableism in medical school admissions and residency selection.  
45 Furthermore, a video-based educational series is in development in collaboration with the  
46 University of Colorado’s Anschutz School of Medicine. This series will equip clinicians with  
47 strategies to improve care for PWD and overcome common barriers in clinical settings.

1 CONCLUSION

2  
3  
4 The AMA Board of Trustees has determined that the DAG will continue for an additional two  
5 years and will continue the meeting cadence set forth in the original DAG Charter. The AMA  
6 Board of Trustees thanks the current DAG Members for all their work since the DAG was made  
7 effective on August 15, 2024. The AMA Board of Trustees will call for nominations for a new  
8 group of AMA members, whose AMA membership is active and in good standing, to serve on the  
9 DAG for the next two years (2026-2028). Current DAG members may reapply to serve during the  
10 2026-2028 term. AMA staff will work with the new DAG membership to continue to improve the  
11 experience and inclusion of PWD by continuing to create educational and training content,  
12 developing policy recommendations, establishing inclusion practices in AMA-led spaces, and  
13 working in consultation with other aligned national organizations such as the AAMC, the  
14 Accreditation Council for Graduate Medical Education, DWDI and other relevant organizations to  
15 improve accommodations for, and inclusion of, PWD, in organized medicine.  
16  
17

Fiscal Note: To be determined

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<sup>1</sup> Meeks LM, Case B, Herzer K, Plegue M, Swenor BK. Change in Prevalence of Disabilities and Accommodation Practices Among US Medical Schools, 2016 vs 2019. *JAMA*. 2019;322(20):2022-2024. doi:10.1001/jama.2019.15372

<sup>2</sup> Nouri Z, Dill MJ, Conrad SS, Moreland CJ, Meeks LM. Estimated Prevalence of US Physicians With Disabilities. *JAMA Netw Open*. 2021;4(3):e211254. doi:10.1001/jamanetworkopen.2021.1254

<sup>3</sup> Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. Centers for Disease Control and Prevention. January 14, 2025. Accessed January 14, 2025. <https://www.cdc.gov/index.htm>

<sup>4</sup> *Americans With Disabilities Act*. 1990. Accessed February 2, 2026. <https://www.ada.gov/pubs/adastatute08.htm>

<sup>5</sup> Hogan AJ. Social and medical models of disability and mental health: evolution and renewal. *CMAJ Can Med Assoc J*. 2019;191(1):E16-E18. doi:10.1503/cmaj.181008

<sup>6</sup> *Id.*

<sup>7</sup> World Health Organization. Disability. 2026. [https://www.who.int/healthtopics/disability#tab=tab\\_1](https://www.who.int/healthtopics/disability#tab=tab_1)

<sup>8</sup> AMA Center for Optimal Health Outcomes. An Introduction to Ableism in Medical Education and Health Care. October 7, 2025. Accessed February 2, 2026. <https://edhub.ama-assn.org/ama-center-optimal-health-outcomes/module/2840024>

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.

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

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1 This report provides an update on the activities of the American Medical Association (AMA) Task  
2 Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is  
3 Banned or Restricted (the Task Force) in accordance with Policies G-605.009, D-5.998, and  
4 D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may  
5 not include more recent developments.)  
6

7 BACKGROUND  
8

9 Policy G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship  
10 When Evidence-Based, Appropriate Care is Banned or Restricted,” was adopted at the 2022  
11 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:  
12

- 13 1. Our AMA will convene a task force of appropriate AMA councils and interested state and  
14 medical specialty societies, in conjunction with the AMA Center for Health Equity, and in  
15 consultation with relevant organizations, practices, government bodies, and impacted  
16 communities for the purpose of preserving the patient-physician relationship.
- 17 2. This task force, which will serve at the direction of our AMA Board of Trustees, will  
18 inform the Board to help guide organized medicine’s response to bans and restrictions on  
19 abortion, prepare for widespread criminalization of other evidence-based care, implement  
20 relevant AMA policies, and identify and create implementation-focused practice and  
21 advocacy resources on issues including but not limited to:
  - 22 a. Health equity impact, including monitoring and evaluating the consequences of  
23 abortion bans and restrictions for public health and the physician workforce and  
24 including making actionable recommendations to mitigate harm, with a focus on the  
25 disproportionate impact on under-resourced, marginalized, and minoritized  
26 communities;
  - 27 b. Practice management, including developing recommendations and educational  
28 materials for addressing reimbursement, uncompensated care, interstate licensure, and  
29 provision of care, including telehealth and care provided across state lines;
  - 30 c. Training, including collaborating with interested medical schools, residency and  
31 fellowship programs, academic centers, and clinicians to mitigate radically diminished  
32 training opportunities;
  - 33 d. Privacy protections, including best practice support for maintaining medical records  
34 privacy and confidentiality, including under HIPAA, for strengthening physician,  
35 patient, and clinic security measures, and countering law enforcement reporting  
36 requirements;
  - 37 e. Patient triage and care coordination, including identifying and publicizing resources for  
38 physicians and patients to connect with referrals, practical support, and legal  
39 assistance;

- 1 f. Coordinating implementation of pertinent AMA policies, including any actions to  
2 protect against civil, criminal, and professional liability and retaliation, including  
3 criminalizing and penalizing physicians for referring patients to the care they need; and
- 4 g. Anticipation and preparation, including assessing information and resource gaps and  
5 creating a blueprint for preventing or mitigating bans on other appropriate health care,  
6 such as gender affirming care, contraceptive care, sterilization, infertility care, and  
7 management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy  
8 complications.

9  
10 Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, “Support for Physicians  
11 Practicing Evidence-Based Medicine in a Post Dobbs Era,” added a requirement for an annual  
12 report of the Task Force. Policy D-5.998(1) instructs that:

- 13
- 14 1. Our AMA Task Force developed under HOD Policy G-605.009, “Establishing A Task  
15 Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate  
16 Care is Banned or Restricted,” will publish a report with annual updates with  
17 recommendations including policies, strategies, and resources for physicians who are  
18 required by medical judgment and ethical standards of care to act against state and federal  
19 laws.

20  
21 At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an  
22 ad hoc committee on payment and reimbursement issues in gender affirming care to the Task  
23 Force’s directives. Specifically, the amendment instructs that:

- 24
- 25 1. Our American Medical Association will appoint an ad hoc committee or task force,  
26 composed of physicians from specialties who routinely provide gender-affirming care,  
27 payers, community advocates, and state Medicaid directors and/or insurance  
28 commissioners, to identify issues with physician payment and reimbursement for gender-  
29 affirming care and recommend solutions to address these barriers to care.

30  
31 At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task  
32 Force:

- 33
- 34 h. Work with interested parties to encourage the development of institution-level  
35 guidance and protection for physicians practicing in states with restrictions potentially  
36 interfering with the patient-physician relationship.

37  
38 Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, “Accountability for  
39 G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force  
40 Update and Guidance,” which states:

- 41
- 42 1. Our American Medical Association’s Task Force, to Preserve the Patient-Physician  
43 Relationship, will present annual updates on their findings at AMA Annual Meetings until  
44 the objectives have been completed.

45  
46 Then at the AMA 2025 Annual Meeting, the HOD adopted Policy D-5.995, “Protecting Access to  
47 Emergency Abortion Care Under EMTALA,” which states:

- 48
- 49 2. Our AMA task force established under AMA Policy G-605.009, “Establishing A Task  
50 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

1 The participating state medical associations include:

- 2
- 3 • California Medical Association
- 4 • Idaho Medical Association
- 5 • The Maryland State Medical Society (MedChi)
- 6 • Massachusetts Medical Society
- 7 • Pennsylvania Medical Society
- 8 • Texas Medical Association
- 9 • Medical Society of Virginia

10

11 In total, there are 29 physician members on the Task Force.

12

13 *Overview of Task Force Meetings*

14

15 As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses  
16 of the issues identified in Policy G-605.009. These landscape analyses identified implementation-  
17 focused practice and advocacy resources on issues including health equity, practice management,  
18 medical education, privacy, and legal issues and identified potential resource gaps. The landscape  
19 analyses were presented to Council representatives monthly, beginning in January of 2024 and  
20 concluding in May of 2024. The landscape analyses were used (and will continue to be used) to  
21 identify key topics of discussion for meetings of the Task Force and were distributed to all Task  
22 Force members prior to the first in-person meeting of the Task Force.

23

24 Since its inception in spring of 2024, the Task Force has held six virtual meetings, four in-person  
25 meetings, and three informational sessions. The virtual meetings were held in May 2024,  
26 December 2024, January 2025, May 2025, October 2025, and December 2025. This total does not  
27 include additional virtual meetings conducted with Task Force subcommittees or project teams. In-  
28 person meetings were held in July 2024, February 2025, July 2025, and February 2026. The  
29 informational sessions were held at the AMA 2024 Interim Meeting in November 2024, the AMA  
30 2025 Annual Meeting in June 2025, and the AMA 2025 Interim Meeting in November 2025.

31

32 Virtual Task Force Meetings

33

34 In 2024, the Task Force held two virtual meetings for all members of the Task Force. The Task  
35 Force held a virtual kick-off meeting in May 2024, in which the Task Force Co-Chairs laid out the  
36 Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the  
37 Task Force held a meeting to discuss the remarks given at the informational session at the  
38 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects.

39

40 In 2025, the Task Force held virtual meetings on a quarterly basis. First, in January 2025, the Task  
41 Force met to review research conducted into strategy and messaging. (Note: Additional details  
42 about the research discussed in the January meeting are provided later in this report.) Then, in May  
43 of 2025, the Task Force met to discuss emerging research into the impact of abortion bans and  
44 restrictions on the workforce. Then, at the Task Force's fifth virtual meeting in October of 2025,  
45 the Task Force met to review and provide feedback on the resource hub the Task Force developed.  
46 (Note: Additional details about the resource hub created by the Task Force are provided later in this  
47 report.) Finally, at the Task Force's sixth virtual meeting in December 2025, the Task Force met to  
48 discuss American College of Obstetricians & Gynecologists (ACOG)'s project to develop and  
49 implement state-specific guidance and protocols at institutions in states banning or restricting  
50 abortion. (Note: Additional details about the project discussed in the December meeting are  
51 provided later in this report.)

1 In addition to the six virtual meetings with all members of the Task Force, numerous virtual  
2 meetings for various Task Force subcommittees and project teams were also held to coordinate  
3 ongoing projects, prepare for upcoming meetings with external stakeholders, and ensure that  
4 project milestones were met.

5  
6 In-Person Task Force Meetings

7  
8 Over the course of two years, the Task Force held four all-day, in-person meetings at the AMA  
9 Headquarters in Chicago. These meetings were structured to focus the Task Force's attention on  
10 the specific aspects of abortion care impact by *Dobbs* and gender-affirming care, as laid out in  
11 AMA Policy G-605.009. Nationally recognized experts in legal issues, payment and  
12 reimbursement for gender-affirming care in adult patients, medical education and training, and  
13 public health and health outcomes equipped Task Force members with the latest information,  
14 research, data, and resources. These presentations and discussions supplemented Task Force  
15 members clinical expertise, supporting discussions to identify relevant resource gaps and  
16 opportunities to fill them.

17  
18 The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting  
19 focused on legal issues in abortion care and featured a range of speakers and presenters on topics  
20 all relating to legal issues in abortion care including, abortion-related litigation activity across the  
21 country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act  
22 (EMTALA), and shield law protections for abortion care providers. Following each presentation,  
23 Task Force members asked questions and discussed issues and concerns. During a working lunch,  
24 Task Force members were asked to strategize and identify resource gaps and potential deliverables  
25 for the Task Force regarding advocacy, health equity, medical education and workforce, legal  
26 issues, practice issues, and public health. The exercise generated numerous ideas for action. At the  
27 conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and  
28 D-5.998, which instructed the Task Force to identify and create implementation-focused practice  
29 and advocacy resources, the Task Force discussed existing resources and limitations of those  
30 resources, and identified gaps where resources need to be developed.

31  
32 In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim  
33 Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and  
34 reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent  
35 the following nine organizations:

- 36
- 37 • AMA Board of Trustees
  - 38 • AMA Council on Legislation
  - 39 • AMA Council on Ethical and Judicial Affairs
  - 40 • American Academy of Child and Adolescent Psychiatry
  - 41 • American Academy of Dermatology
  - 42 • American Psychiatric Association
  - 43 • American Society for Reproductive Medicine
  - 44 • The Endocrine Society
  - 45 • Idaho Medical Association
- 46

47 AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder  
48 access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified  
49 existing resources and gaps in those resources and helped inform discussion during in-person  
50 meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement

1 for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's  
2 meeting in February 2025 dedicated to these issues.

3  
4 One of the issues identified by the subcommittee was challenges arising from CPT® coding for  
5 gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section  
6 to field a survey to better understand these coding challenges. The input from this survey aided the  
7 Task Force's discussion of coding issues during its February 2025 meeting.

8  
9 As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues  
10 with physician payment and reimbursement for gender-affirming care and recommend solutions to  
11 address these barriers to care." The meeting featured a range of speakers on topics all involving  
12 payment and reimbursement limitations and administrative challenges that impede access to  
13 gender-affirming care for adults, including challenges stemming from limited or non-specific  
14 billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and  
15 policies, and state and federal efforts to restrict or criminalize access to gender-affirming care.  
16 Speakers included physicians who provide gender-affirming care to adult patients, attorneys,  
17 coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to  
18 allow ample time after each presentation for Task Force members to ask questions of the presenters  
19 and discuss barriers to care with one another. These discussions focused on the current landscape  
20 and highlighted potential pain points for physicians and patients. Much of the discussion also  
21 centered around recent federal executive orders to prohibit federal funding of services for minors  
22 and the impact those policies could have on care for other populations. In the last session of the  
23 meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task  
24 Force to recommend solutions to these barriers to care, the Task Force members discussed  
25 opportunities and strategies for improving access to care and alleviating administrative burden,  
26 including working towards creating more specific CPT codes, where appropriate, continuing to  
27 advocate against criminalization, and supporting physicians who care for transgender and gender  
28 diverse patients. This discussion was informed by Task Force members' perspectives as clinicians,  
29 the speaker presentations, and discussions throughout the meeting.

30  
31 In July 2025, the Task Force held its third in-person meeting. Featuring nine speakers across four  
32 sessions, the meeting's agenda focused on the impact of medical care restrictions on medical  
33 education, training, and the physician workforce. In the first session of the morning, speakers from  
34 the Accreditation Council on Graduate Medical Education (ACGME) examined program  
35 requirements, challenges facing training programs, and the impact of abortion restrictions on  
36 clinical training. The meeting's second session explored opportunities to expand clinical training  
37 options for trainees, including how programs are adapting to the post-*Roe* environment and how the  
38 legislative landscape is impacting clinical training in gender-affirming care. During the meeting's  
39 third session, Task Force members heard from a resident and two medical students about the  
40 challenges they are facing, how abortion care restrictions are impacting residents and medical  
41 students' educational opportunities, and how the current legislative landscape is affecting LGBTQ+  
42 residents and medical students' medical education. In the meeting's last session, speakers from the  
43 American Association of Medical Colleges (AAMC) discussed the impact of abortion restrictions  
44 on medical schools and the physician workforce pipeline, highlighting research into changes in  
45 residency applications in states with abortion restrictions. During the final session of the meeting,  
46 as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct  
47 the Task Force to identify and create implementation-focused practice and advocacy resources, the  
48 Task Force discussed existing resources and limitations of those resources, and identified gaps  
49 where resources need to be developed.

1 The Task Force held its fourth and final all-day, in-person meeting in February of 2026. The goal  
2 of the Task Force's fourth meeting was to examine the intersection of abortion and public health  
3 and identify and evaluate available resources to help physicians and medical students navigate  
4 those issues. Invited speakers across four discussions and presentations focused the conversation on  
5 various facets of public health or health care delivery and the challenges faced by physicians,  
6 medical students, and patients in that space. The meeting's agenda included a discussion on the  
7 current political and legal landscape, a presentation on *Dobbs*' impact on health care delivery and  
8 health outcomes, a presentation on issues and disparities in medication abortion access, and a  
9 presentation on the impact of *Dobbs* on medical liability and population health. Following each  
10 presentation, the Task Force asked questions of the presenter, discussed the issues raised, and  
11 discussed resources available or needed to support physicians and medical students.

### 12 Informational Sessions

14  
15 In accordance with AMA policy, which directs the Task Force to present updates of its findings  
16 including policies, strategies, and resources, the Task Force hosted a series of informational  
17 sessions at Annual and Interim meetings of the HOD. These informational sessions served to  
18 facilitate engagement with AMA Delegates, Alternate Delegates, and representatives from the  
19 AMA Sections and to elevate important voices that are not members of the Task Force.

20  
21 The Task Force hosted its first informational session at the AMA's 2024 Interim Meeting. At the  
22 session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in  
23 2024. Following the presentation, selected representatives from the AMA's Sections were invited  
24 to provide remarks about their experience with laws restricting or banning reproductive health care.  
25 The representatives' remarks focused on state laws' impacts on patient care, career and family  
26 decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician  
27 stress and anxiety. The selected speakers from the AMA Sections represented:

- 28
- 29 • Women Physicians Section
- 30 • Medical Student Section
- 31 • Resident and Fellow Section
- 32 • Young Physicians Section
- 33 • Minority Affairs Section
- 34 • LGBTQ+ Section
- 35 • Private Practice Physician Section
- 36 • Organized Medicine Staff Section
- 37 • Academic Physicians Section
- 38 • International Medical Graduates Section
- 39 • Senior Physician Section
- 40

41 After the representatives from AMA's Sections spoke, AMA Delegates, Alternate Delegates, and  
42 other interested parties were invited to ask questions or provide remarks on issues being considered  
43 by the Task Force that had not been addressed by previous speakers. These speakers focused their  
44 remarks on requests for more communication about the Task Force's work and opportunities for  
45 future engagement with the Task Force.

46  
47 Then at the Annual Meeting of the HOD in June of 2025, the Task Force hosted its second  
48 informational session. The purpose of the informational session was to continue engagement with  
49 the AMA Delegates, Alternate Delegates, Council members, representatives from AMA Sections  
50 and other interested parties. During the informational session, the Task Force showcased some of  
51 the research and resources it has developed to support physicians navigating the post-*Roe* legal

1 landscape. The highlighted resources included a presentation on messaging strategy and a  
 2 presentation on the legal assistance available from the Abortion Defense Network. (Note:  
 3 Additional details about the messaging strategy and the legal assistance resources are provided later  
 4 in this report.) In addition, the informational session included a question-and-answer portion to  
 5 provide an opportunity to ask questions of the Task Force and an opportunity to share perspectives  
 6 on its work. The perspectives shared by Delegates, Alternate Delegates, representatives from AMA  
 7 Sections and other interested parties at the informational session were informative, shaping how the  
 8 Task Force approached its ongoing work.

9  
 10 Once again at the Interim meeting of the HOD in November of 2025, the Task Force hosted a third  
 11 informational session to facilitate resource-sharing and engagement with AMA Delegates, AMA  
 12 Alternate Delegates, Council members, representatives from AMA Sections, and other interested  
 13 parties. At this informational session, the Task Force launched its website: the Reproductive Health  
 14 Resource Navigator, which is a resource hub for physicians navigating abortion bans and  
 15 restrictions. (Note: The Reproductive Health Resource Navigator is available at  
 16 <https://www.rhrnavigator.org/>. Additional details about the Reproductive Health Resource  
 17 Navigator are provided later in this report.) Following a demonstration and overview of the  
 18 website, invited speakers gave presentations on resources their organizations offer to physicians,  
 19 residents, and medical students. Repeatedly in conversations with AMA Sections and other  
 20 interested parties, the Task Force has heard about the need for legal assistance for physicians  
 21 navigating the post-*Roe* legal landscape. In response, at the informational session the Task Force  
 22 hosted the Abortion Defense Network to present on the legal assistance, representation, and legal  
 23 defense funding that they provide to physicians navigating the post-*Roe* legal landscape. Then  
 24 during their presentation, the Ryan Residency Training Program examined the current clinical  
 25 training landscape and discussed their efforts to provide out-of-state clinical training opportunities  
 26 to residents in states with abortion bans and restrictions.

27  
 28 In the last portion of the informational session, attendees were invited to ask questions of the  
 29 presenters and share their perspectives on the work of the Task Force. This engagement from  
 30 attendees was extremely important to the Task Force and ensured that the perspectives and  
 31 experiences from members of the HOD and AMA Sections are considered in the work of the Task  
 32 Force. These remarks highlighted important requests and concerns for the Task Force to address in  
 33 its work. As it contemplates its work in 2026, the Task Force reaffirms its commitment to ensuring  
 34 underrepresented voices continue to be uplifted through its work.

35  
 36 Task Force Outreach

37  
 38 In addition to the informational sessions, the Task Force conducted outreach with any interested  
 39 AMA Sections, AMA Councils, and specialty groups in the lead up to the past three HOD meetings  
 40 and met with the groups at their request. As part of this outreach, the Task Force met with AMA's  
 41 Council on Legislation, Council on Medical Service, and ACOG's delegation to the HOD. In  
 42 addition, these meetings facilitated open communication and provided a forum for valuable  
 43 dialogue with AMA Sections, including the AMA Women Physicians Section, AMA LGBTQ+  
 44 Section, AMA Academic Physicians, and AMA Medical Students Section. The perspectives shared  
 45 during these meetings were critical in shaping the Task Force's work and ensuring that pressing  
 46 needs, requests, and concerns are addressed. For example, as part of this engagement and to  
 47 address concerns raised during these discussions, the Task Force partnered on a survey with the  
 48 LGBTQ+ Section that focused on physician well-being and informed the development of well-  
 49 being resources.

1 *Ongoing Projects of the Task Force*

2  
3 As a result of reproductive care resource gaps identified by the Task Force, and at the direction of  
4 the Board, AMA staff has undertaken a series of projects and initiated partnerships and  
5 collaborations to fill those gaps.

6  
7 Reproductive Health Resource Navigator

8  
9 In accordance with the directive to identify and create implementation-focused practice and  
10 advocacy resources, the Task Force recommended that AMA develop a website, the Reproductive  
11 Health Resource Navigator, to serve as a resource hub for physicians navigating abortion bans and  
12 restrictions. The AMA agreed that this was a priority and supported the funding of its development.  
13 The website is publicly available at <https://www.rhrnavigator.org/>. The Reproductive Health  
14 Resource Navigator houses more than 300 resources developed by the Task Force, AMA, state  
15 medical associations and national medical specialty societies, and external organizations. The  
16 resources address legal considerations, clinical care, practice management, medical education, and  
17 patient resources and are organized in by topic in a searchable format. In accordance with the  
18 directive in Policy D-5.995 to provide resources to assist physicians navigating conflicting state  
19 and federal regulations on emergency pregnancy care, the site also includes guidance on complying  
20 with EMTALA obligations. Additionally, legal representation resources and physician well-being  
21 resources are highlighted for site visitors.

22  
23 Public Opinion Research and Messaging

24  
25 To support coordinated advocacy, effective engagement, and in accordance with the directive to  
26 guide organized Medicine's response to abortion restrictions, the Task Force recommended AMA  
27 commission qualitative public opinion research using surveys, in-depth interviews, and focus  
28 groups. The research helped explain how different messages, language, and tone resonate across  
29 key constituent audiences and build a more compelling narrative for reproductive health advocacy  
30 grounded in a strategic messaging foundation. The research provided insight for Task Force  
31 members and their organizations on physicians' and the public's perception of the current  
32 reproductive health care landscape and will inform strategy for the Task Force going forward. The  
33 Task Force met in January 2025 to review the research findings. Findings were also shared with  
34 Task Force member organizations and other Federation of Medicine partners.

35  
36 Research on the Workforce Impact

37  
38 To better understand how abortion bans and restrictions impact the physician workforce and to  
39 carry out the directive that the Task Force monitor workforce impacts, the Task Force  
40 recommended AMA conduct research on the impact of abortion bans and restrictions on the  
41 physician workforce and again, the AMA agreed to fund this research. Accordingly, AMA staff  
42 initiated a research project examining the impact of abortion restrictions on the physician  
43 workforce and where physicians choose to practice. The research and mapping project was  
44 completed in spring 2025 and the findings were presented to Task Force members during its virtual  
45 meeting in May of 2025.

46  
47 Legal Assistance and Resources for Physicians

48  
49 In accordance with the directive to publicize resources for physicians to connect with legal  
50 assistance and to protect physicians against civil or criminal prosecution, the Task Force worked  
51 with the AMA to support the Abortion Defense Network (ADN) and their network of attorneys and

1 law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal  
2 landscape. ADN’s resources are available to physicians and other health care providers at  
3 [www.abortiondefensenetwork.org](http://www.abortiondefensenetwork.org). Their resources include 26 in-depth “Know Your State’s  
4 Abortion Laws” guides for medical professionals, which aim to provide clarification on what  
5 conduct is permitted and what the law requires in states with abortion restrictions. The partnership  
6 between the Task Force and ADN resulted in 10 additional state law guides (Alabama, Arizona,  
7 Mississippi, Montana, Nevada, New Hampshire, North Dakota, South Dakota, Virginia, and West  
8 Virginia). The guides cover state laws and professional guidelines on numerous facets of  
9 reproductive health care, including medication abortion, contraception, and obligations under  
10 EMTALA. The state law guides are available on the ADN’s website at  
11 <https://abortiondefensenetwork.org/resources/providers/>.

12  
13 In addition to their written legal resources, ADN connects physicians and others involved in  
14 providing abortion care with personalized legal advice and financial assistance. The Task Force  
15 urged AMA to support greater physician access to legal assistance, representation, and legal  
16 defense funding to physicians navigating the post-*Roe* legal landscape. AMA agreed and provided  
17 financial assistance to ADN. Physicians and medical professionals seeking personalized legal  
18 assistance can contact ADN using their online form at [https://abortiondefensenetwork.org/get-in-](https://abortiondefensenetwork.org/get-in-touch/)  
19 [touch/](https://abortiondefensenetwork.org/get-in-touch/). After submitting the form, physicians and medical professionals can expect a response from  
20 an attorney within 24 hours. ADN’s legal assistance is typically provided *pro bono*. In instances  
21 where additional legal funding assistance for a civil or administrative action is needed, physicians  
22 and medical professionals may be able to access legal defense funds through ADN.

23  
24 Through 2025 and 2026, AMA staff has continued regular meetings with ADN to discuss  
25 opportunities to collaborate, publicize, and promote ADN’s legal services and resources. In  
26 addition, these meetings have covered the development of additional ADN resources, including  
27 “Know Your Rights” one-pagers and resources related to EMTALA.

### 28 29 Institution-level Guidance

30  
31 In accordance with a directive adopted at the 2024 Interim Meeting instructing the Task Force to  
32 work with interested parties to encourage the development of institution-level guidance, the Task  
33 Force is collaborating with ACOG to promote adoption of state-specific, institution-level guidance  
34 for managing pregnancy-related medical emergencies in states with abortion restrictions. Using  
35 sample protocols drafted by ACOG with support from Lawyers for Good Government, this  
36 initiative clarifies institutional policies on abortion to ensure pregnant patients receive appropriate  
37 medical care in compliance with state law.

38  
39 The institutional guidance project is a joint initiative of ACOG and Lawyers for Good Government,  
40 with support from the Society for Maternal-Fetal Medicine and the AMA. At ACOG’s request, the  
41 AMA added a statement of support to ACOG’s protocol materials. ACOG also requested the AMA  
42 help make connections with individuals and organizations who could help support adoption of the  
43 protocol. To further the initiative, the AMA’s role has been to support the targeted and intentional  
44 promotion of the project, identify champions to advance the protocols at their own institutions, and  
45 connect ACOG to relevant state-level contacts. To accomplish this, the AMA facilitated  
46 convenings and information sharing with relevant state medical associations, the AMA’s  
47 Organized Medical Section, and the AMA’s Integrated Physician Practice Section. AMA is eager  
48 to continue supporting ACOG in the implementation of this project and looks forward to the  
49 continued collaboration.

1 Collaboration with Elected Prosecutors and District Attorneys

2  
3 To gain clarity on how abortion bans may be enforced against physicians, and in accordance with  
4 AMA policy to protect against civil, criminal, and professional liability and retaliation, the Task  
5 Force identified an opportunity to engage with an organization representing elected prosecutors and  
6 district attorneys nationwide. The AMA agreed that this would be a productive use of time and  
7 resources and, as a result, in March of 2025, seven Task Force members participated in a full day  
8 convening with elected prosecutors from around the country. The convening helped professionals  
9 on each side understand the others' perspectives, processes, and challenges, and brainstorm  
10 strategies to mitigate risk of prosecution for physicians providing abortion care under exceptions in  
11 state law. Following the March meeting, a local convening modeled after the national meeting was  
12 held. This meeting convened local prosecutors, state legislators, and local physician leaders.

13  
14 Continuing the collaboration, a new group of seven Task Force members attended a second  
15 convening with the national prosecutors' group in December of 2025. As a result of this meeting,  
16 the Task Force and participating prosecutors are planning two upcoming webinars to educate both  
17 prosecutors and physicians. Specifically, one webinar will educate physicians about the criminal  
18 prosecution process and relevant legal standards; the other webinar will educate prosecutors about  
19 pregnancy complications and the incompatibility between abortion laws and clinical practice. This  
20 work is on-going. (Note: This report was prepared in February and may not include more recent  
21 developments.) The AMA is continuing to collaborate with prosecutor groups to educate the  
22 prosecution field and establish collaborative relationships to help inform prosecutorial actions.

23  
24 Support for Residents and Medical Students

25  
26 As a result of the Task Force's discussions on challenges and barriers facing medical students and  
27 residents, and in accordance with AMA policy to mitigate radically diminished training  
28 opportunities, AMA staff initiated several projects and collaborations to support residents and  
29 medical students navigating bans and restrictions on abortion. The Task Force recommended that  
30 the AMA provide financial assistance to facilitate out-of-state training opportunities. The AMA  
31 agreed and helped fund the UCSF Ryan Residency Training Program in order to provide financial  
32 assistance to enable residents in ban states to travel to out-of-state institutions for abortion training,  
33 support for institutions who receive out-of-state residents, and build capacity within the Ryan  
34 Residency Training Program to further support institutional partnerships to ensure availability of  
35 abortion training.

36  
37 All OB-GYN residency programs are required by ACGME to provide training in abortion care. In  
38 states where abortion is banned or severely restricted, residency programs cannot fulfill this  
39 requirement without sending residents to external sites. Many institutions, particularly in the South  
40 and Midwest, report that they lack resources or face legal or policy barriers to funding residents'  
41 travel, leaving residents personally responsible for those costs. The AMA's financial assistance for  
42 resident travel costs help to fill that gap, ensuring that residents are able to accept temporary  
43 placement and gain competency in managing abortion, miscarriage, and pregnancy complications.

44  
45 A critical barrier to maintaining out-of-state training partnerships is the strain placed on the clinical  
46 sites that host visiting residents. These receiving institutions must absorb significant administrative,  
47 supervisory, and logistical burdens, from processing temporary licenses, malpractice coverage, and  
48 onboarding requirements to adjusting clinic schedules and supervision ratios to accommodate  
49 additional trainees. Many are safety-net or academic centers already operating at capacity. The  
50 Ryan Program will provide direct financial and technical support to these host institutions, helping  
51 offset the costs of integrating visiting residents while preserving high-quality training for all

1 learners. By supporting receiving institutions, the contribution will help ensure these cross-state  
2 partnerships remain sustainable for receiving institutions.

3  
4 While short-term funding for resident placements is urgently needed, the Ryan Program's broader  
5 infrastructure helps make those rotations possible. The Ryan Program serves as the central  
6 convener and technical resource for residency programs navigating legal, logistical, and  
7 educational complexities in the post-*Dobbs* environment. The AMA's funding helped enable the  
8 program to expand and formalize these efforts by developing standardized affiliation agreements,  
9 refining compliance and risk-management tools, facilitating communication between sending and  
10 receiving sites, and building the capacity of faculty and program administrators to manage these  
11 cross-state collaborations effectively. This investment ensures that the national system for  
12 arranging out-of-state training is scalable and sustainable for the future.

13  
14 Lastly, in response to the Task Force's discussions on moral distress, trainee mental health, and the  
15 need to support medical student well-being, the AMA published two issue briefs on moral distress  
16 in medical students, available resources, and AMA policies to support medical student well-being.  
17 These issue briefs are available at [https://www.ama-assn.org/system/files/Issue-brief-moral-](https://www.ama-assn.org/system/files/Issue-brief-moral-distress.pdf)  
18 [distress.pdf](https://www.ama-assn.org/system/files/issue-brief-med-student-resources.pdf) and <https://www.ama-assn.org/system/files/issue-brief-med-student-resources.pdf>.

19  
20 The Task Force continues to consider additional deliverables to support physicians navigating state  
21 laws restricting or banning abortion.

## 22 23 CONCLUSION

24  
25 The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998,  
26 monitor and prepare for new and emerging threats to the provision of evidenced-based medical  
27 care, and work to protect access to care and preserve the role of the patient-physician relationship  
28 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

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1 The Council on Constitution and Bylaws (CCB) submitted CCB Report 3-I-25 to the House of  
2 Delegates (HOD) for consideration. The report drew extensive testimony in the online reference  
3 committees. The Reference Committee on Ethics and Bylaws in its preliminary report had  
4 difficulty with a report this complex and nuanced, particularly as online testimony included various  
5 amendments. After reviewing the preliminary report that contained 21 recommendations, CCB  
6 reviewed the extensive online testimony, proposed amendments, and the preliminary reference  
7 committee report, and submitted a revised report reflecting some of the testimony and amendments  
8 in the hopes that the revised report would be easier to manage at the reference committee hearing.  
9 Ultimately, after extensive debate on multiple aspects of the report, the HOD referred the report  
10 back to CCB for a report at A-26, along with Resolution 10-I-25. The resolution from the Medical  
11 Student (MSS) and the Resident and Fellow (RFS) Sections asked that the bylaws be amended to  
12 explicitly allow these sections to appoint rather than elect individuals to serve as temporary  
13 delegates and alternate delegates to fill vacancies and absences.

14  
15 Admittedly, CCB Report 3-I-25 was a lengthy report that touched on a myriad of topics, many of  
16 which were nuanced. As the Council discussed appropriate follow-up, it determined that to make  
17 its proposed amendments more easily digestible and manageable for HOD members and the  
18 reference committee at A-26, it was preferable to issue a series of shorter reports, each focusing on  
19 a distinct issue addressed in CCB 3-I-25 and Resolution 10-I-25. For each report, the Council has  
20 also included the final clean bylaw language if the report is adopted. Included as an appendix to  
21 this report is a clean copy of the affected provisions of Bylaw 2 (Appendix B) if CCB 2-7 reports  
22 were adopted. Additionally, the Council has included as an appendix (Appendix A) a taxonomy of  
23 the existing and amended bylaw changes, and the source CCB report of those changes. Lastly,  
24 Appendix C includes a chart with links to the Bylaws of all entities with HOD representation for  
25 easy reference.

26  
27 Report topics are as follows:

- 28
- 29 • CCB Report 2, HOD Representation and Composition
    - 30 – This report provides some amended language to emphasize the inclusive nature of the
    - 31 HOD.
  - 32 • CCB Report 3, Rights & Privileges of HOD Members
    - 33 – This report explicitly sets forth the rights and privileges afforded to delegates
    - 34 paralleling existing bylaw language that articulates the rights and privileges of the
    - 35 alternate delegates, ex officio members, official observers, and temporary delegates.
  - 36 • CCB Report 4, Credentialing of HOD Delegates and Alternate Delegates
    - 37 – This report identifies the appropriate credentialing authority for all entities represented
    - 38 in the HOD, respecting the unique nature of the section HOD delegates and alternates,
    - 39 medical student regional delegates and alternates and the resident and fellow sectional

- 1 delegates and alternates. The updated term ‘credentialing’ replaces ‘certification’  
2 which refers to a process that is no longer utilized. Lastly, some existing language is  
3 clarified for accuracy and consistency.
- 4 • CCB Report 5, Inclusion of Medical Students and Resident/ Fellow Physicians in HOD  
5 Delegations
    - 6 – This report reinstates language proposed for deletion in CCB 3-1-25, language which  
7 states that a medical student or a resident/fellow may be hold a constituent association  
8 delegation seat. It also establishes an equivalent ability for the national medical  
9 specialty societies and professional interest medical associations to seat a medical  
10 student or a resident/fellow as delegation members.
  - 11 • CCB Report 6, Medical Student Regional Delegates and Alternate Delegates and Resident  
12 and Fellow Sectional Delegates
    - 13 – This report addresses the bylaws associated with the medical student regional delegates  
14 and alternate delegates and resident and fellow sectional delegates and alternate  
15 delegates, including their eligibility for election, the mechanism by which they are  
16 elected, and their unique seating assignment in the HOD.
  - 17 • CCB Report 7, HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
    - 18 – This report eliminates the confusing distinction between a substitute delegate and a  
19 temporary substitute delegate and specifies the process by which a vacancy may be  
20 filled after the credentialing deadline, and the process to fill an open seat due to a  
21 meeting absence. This report also addresses Resolution 10-I-25 by granting the  
22 sections the ability to credential a temporary delegate or temporary alternate delegate  
23 when there are no available elected alternate delegates.

24  
25 The Council hopes that by separating these complex and nuanced issues the AMA Bylaws will be  
26 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

<b>Existing Bylaws</b>	<b>Amended Bylaws</b>	<b>Source of Proposed Amended Bylaws and Comments</b>
<b>2.0.1 Composition and Representation</b>	<b>2.0.1 Composition and Representation</b>	<b>CCB 3</b> – 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	<b>CCB 2</b> – 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	<b>CCB 2</b> – Acknowledges resident and fellows and medical students are represented in the HOD
2.0.1.2.1 Consideration	2.0.1.2.1 Consideration	<b>CCB 2</b> – 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	<b>CCB 2</b> – 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.	<b>CCB 3</b> – 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	<b>CCB 3</b> – 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	<b>CCB 2</b> – Retitled to address representation by an individual of only a single society
(New)	2.0.1.5 Registration	<b>CCB 2</b> – Specifies the need for every attendee to register for HOD meetings
2.0.1.3 Autonomy	2.0.1.6 Autonomy	<b>CCB 2</b> – Numbering change
<b>2.1 Constituent Associations</b>	<b>2.1 Constituent Association Delegations</b>	<b>CCB 2</b> – Edits for consistent terminology across all represented societies
2.1.1 Apportionment	2.1.1 Apportionment	<b>CCB 2</b> – 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	<b>CCB 2</b> – Incorporates language from former 2.10.1
2.1.2 Selection	2.1.2 Selection	<b>CCB 5</b> – Edits for accuracy
2.1.3 Certification	2.1.3 Credentialing	<b>CCB 4</b> – Edits for accuracy
2.1.4 Term	2.1.4 Term	<b>CCB 2</b> – Edits for completeness and accuracy
2.1.5 Vacancies	2.1.5 Vacancies	<b>CCB 7</b> – 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	<b>CCB 5</b> – 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	<b>CCB 5</b> – Edits for accuracy
2.1.6.2 No Restriction on Selection	2.1.6.2 No Restriction on Selection	<b>CCB 5</b> – 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
<b>2.2 National Medical Specialty Societies.</b>	<b>2.2. National Medical Specialty Society Delegations</b>	<b>CCB 2</b> – Edits for consistent terminology across all represented societies
2.2.1 Apportionment	2.2.1 Apportionment	<b>CCB 2</b> – 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	<b>CCB 2</b> – Incorporates language from existing 2.10.1
2.2.2 Selection	2.2.2 Selection	<b>CCB 5</b> – Edits for accuracy

2.2.3 Certification	2.2.3 Credentialing	<b>CCB 4</b> – Edits for accuracy
2.2.4 Term	2.2.4 Term	<b>CCB 2</b> – Edits for completeness and accuracy
2.2.5 Vacancies	2.2.5 Vacancies	<b>CCB 7</b> – Edits for completeness and accuracy delegates
(New)	2.2.6 Resident and Fellow Physician and Medical Student Delegates and Alternate Delegates	<b>CCB 5</b> – Acknowledges a specialty society can credential a medical student or resident/fellow
(New)	2.2.6.1 Term	<b>CCB 5</b> – 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.	<b>CCB 5</b> – Acknowledges a specialty can credential a medical student or resident/fellow for a (full) two-year term
<b>2.3 Medical Student Regional Delegates</b>	<b>2.3. Medical Student Regional Delegates and Alternate Delegates</b>	<b>CCB 6</b> – Edits for consistent terminology across all represented societies
2.3.1 Qualifications	2.3.1 Qualifications	<b>CCB 6</b> – 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	<b>CCB 6</b> – Edits for accuracy
2.3.2.1 Effective Date	2.3.2.1 Effective Date	<b>CCB 6</b> – Edits for accuracy
2.3.3 Election	2.3.3 Election	<b>CCB 6</b> – 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	<b>CCB 4</b> – Edits for accuracy
2.3.5 Term	2.3.5 Term	<b>CCB 7</b> – Deletes redundant language related to credentialing
2.3.6 Vacancies	2.3.6 Vacancies	<b>CCB 7</b> – Edits for completeness and accuracy delegates
(formerly 2.10.8)	2.3.7 Medical Student Seating	<b>CCB 6</b> – Included here for completeness; edits for accuracy.
<b>2.4 Delegates from the Resident and Fellow Section</b>	<b>2.4 Resident and Fellow Sectional Delegates and Alternate Delegates</b>	<b>CCB 6</b> – Edits for consistent terminology across all represented societies

2.4.1 Qualifications	2.4.1 Qualifications	<b>CCB 6</b> – 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	<b>CCB 6</b> – Edits for accuracy
2.4.2.1 Effective Date	2.4.2.1 Effective Date	<b>CCB 6</b> – Edits for accuracy
2.4.3 Election	2.4.3 Elections	<b>CCB 6</b> – 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	<b>CCB 4</b> —Edits for accuracy
2.4.5 Term	2.4.5 Term	<b>CCB 6</b> – Edits for accuracy
2.4.6 Vacancies	2.4.6 Vacancies	<b>CCB 7</b> – Edits for completeness and accuracy
(formerly 2.10.9)	2.4.7 Resident and Fellow Seating	<b>CCB 6</b> – Included here for completeness; edits for accuracy,
<b>2.5 Speaker and Vice Speaker Additional Delegate</b>	<b>2.5 Speaker and Vice Speaker Additional Delegates</b>	<b>CCB 3</b> – Edits for consistency and accuracy
2.5.1 Status of Speaker and Vice Speaker	2.5.1 Rights and Privileges	<b>CCB 3</b> – Retitled Rights & Privileges
2.5.2 Term	2.5.2 Term	No changes
<b>2.6 Other Delegates</b>	<b>2.6 Other Delegates and Alternate Delegates</b>	<b>CCB 2</b> – Edits for consistent terminology across all represented societies
2.6.1 Certification	2.6.1 Credentialing	<b>CCB 4</b> – Edits for accuracy
2.6.2 Term	2.6.2 Term	<b>CCB 2</b> – Edits for completeness and accuracy; <b>CCB 4</b> – Deletes language redundant to that in 2.6.1.
(new)	2.6.2.1 Resident/Fellow Physician and Medical Student Delegates	<b>CCB 5</b> – Acknowledges ability of these groups to credential a medical student or resident/fellow
(new)	2.6.2.1.1	<b>CCB 5</b> – Acknowledges these groups can credential a medical student or resident/fellow for a one year term
(new)	2.6.2.1.2	<b>CCB 5</b> – 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	<b>CCB 7</b> – Edits for completeness and accuracy delegates
	2.6.4 No Restriction on Selection	<b>CCB 5</b> – Acknowledges a medical student or resident and fellow physician may serve a full two-year term
<b>2.7 Ex Officio Members</b>	<b>2.7 Ex Officio Members</b>	No changes
2.7.1 Rights and Privileges	2.7.1 Rights and Privileges	No changes
<b>2.8 Alternate Delegates</b>	---	<b>CCB 2</b> – Incorporated into new 2.0.1.3 with edits for completeness and accuracy
2.8.1 Qualifications	---	<b>CCB 3</b> – Deleted as existing language was incorporated in updated delegation language for each represented society
2.8.2 Certification	---	<b>CCB 3</b> – Existing language was incorporated in updated delegation language for each represented society
2.8.3 Term	---	<b>CCB 3</b> – Existing language was incorporated in updated delegation language for each represented society
2.8.4 Vacancies	---	<b>CCB 3</b> – Existing language was incorporated in updated delegation language for each represented society
2.8.5 Rights and Privileges	(now 2.0.1.3.1)	<b>CCB 3</b> – 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)	<b>CCB 3</b> – see above
---	<b>2.8 Additional Alternate Delegates (new heading)</b>	<b>CCB 3</b> – New Heading
(formerly 2.10.5)	2.8.1 Constituent Association President	<b>CCB 3</b> – Edits for accuracy
(formerly 2.10.6)	2.8.2 National Medical Specialty Society or Professional Interest Medical Association President	<b>CCB 3</b> –Edits for accuracy
<b>2.9 Official Observer</b>	<b>2.9 Official Observer</b>	No changes
2.9.1 Rights and Privileges	2.10.1 Rights and Privileges	No changes
<b>2.10 Registration and Seating of Delegates</b>	<b>2.10 Temporary Delegates and Alternate Delegates</b>	<b>CCB 7</b> – Retitled
2.10.1 Notification	---	<b>CCB 2</b> – Eliminates redundant language
2.10.2 Credentials	---	<b>CCB 7</b> – Eliminates redundant language
2.10.3 Lack of Credentials	---	<b>CCB 7</b> – Eliminates redundant language

2.10.4 Substitute		<b>CCB 7</b> – Incorporated into <u>new</u> 2.10.2
2.10.4.1 Temporary Substitute Delegates	---	<b>CCB 7</b> – Deletes obsolete language
(new)	2.10.1 Temporary Delegates	<b>CCB 7</b> – A credentialing authority may credential a temporary delegate
(new)	2.10.1.1	<b>CCB 7</b> – A delegate not credentialed by the credentialing deadline may be credentialed as a temporary delegate
(new)	2.10.1.2	<b>CCB 7</b> – An alternate delegate may be credentialed as a temporary delegate when the delegate is unavailable
(new)	2.10.1.3	<b>CCB 7</b> – A temporary alternate delegate may be credentialed as a temporary delegate when an delegate is unavailable
(new)	2.10.1.4	<b>CCB 7</b> – Temporary delegates must be credentialed the day before an AMA election in order to vote
(new)	2.10.2 Temporary Alternate Delegates	<b>CCB 7</b> – A credentialing authority may credential a temporary delegate
(new)	2.10.2.1	<b>CCB 7</b> – An alternate delegate not credentialed by the credentialing deadline may be credentialed as a temporary alternate delegate
(new)	2.10.2.2	<b>CCB 7</b> – 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	<b>CCB 7</b> – 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	<b>CCB 7</b> – 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)	<b>CCB 3</b> –Language now under new heading Additional Alternate Delegates for better organization

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2.10.6 National Medical Specialty Society or Professional Interest Medical Association President	(now 2.8.2)	<b>CCB 3</b> – Language now under new heading Additional Alternate Delegates for better organization
2.10.7 Representation	(now 2.0.1.3)	<b>CCB 2</b> –Incorporated into 2.0.1.3 for completeness
2.10.8 Medical Student Seating	(now 2.3.7)	<b>CCB 6</b> – Incorporated under the bylaws governing medical student regional delegates and alternate delegates
2.10.9 Resident and Fellow Seating	(now 2.4.7)	<b>CCB 6</b> – 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 selection 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 selection 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.

Appendix C to CCB Report 1-A-26

The following chart provides a link to the Bylaws that provide more details about each entity represented in the HOD:

<b>Represented Entity</b>	<b>Relevant Bylaw</b>	<b>Selection Mode</b>
Constituent Association	<a href="#">2.1.2</a>	Selected
National Medical Specialty Society	<a href="#">2.2.2</a>	Selected
Medical Student Regional Delegates and Alternates Delegates	<a href="#">2.3.3</a>	Elected. Bylaw <a href="#">7.3.4.3</a> specifies the timing of the elections.
Resident and Fellow Sectional Delegates and Alternate Delegates	<a href="#">2.4.3</a>	Elected. Bylaw <a href="#">7.1.6.2</a> specifies the timing of the election.
AMA Sections ( <a href="#">MSS</a> , <a href="#">RFS</a> , <a href="#">YPS</a> , <a href="#">SPS</a> , <a href="#">APS</a> , <a href="#">OMSS</a> , <a href="#">IMGS</a> , <a href="#">UMAS</a> , <a href="#">IPPS</a> , <a href="#">WPS</a> , <a href="#">PPPS</a> , <a href="#">LGBTQ+ Section</a> )	<a href="#">2.6</a>	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	<a href="#">2.6</a>	Selected
National Medical Association	<a href="#">2.6</a>	Selected
American Medical Women's Association	<a href="#">2.6</a>	Selected
American Osteopathic Association	<a href="#">2.6</a>	Selected
Professional Interest Medical Association	<a href="#">2.6</a>	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

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1 Policy [D-345.970\(3\)](#), “Carceral Systems and Practices in Behavioral Health,” was adopted at the  
2 2025 AMA Annual Meeting, and directs the following:

3

4 3. Our AMA asks the Council on Ethical and Judicial Affairs to study this topic to provide  
5 clearer guidance for healthcare professionals regarding interactions with law enforcement  
6 while caring for patients and shackling of youth and adults in carceral custody, with particular  
7 attention to the removal of.

8

9 The medical care of persons in legal custody presents a range of complex ethical considerations for  
10 physicians and other health professionals. When caring for individuals in legal custody, physicians  
11 may face competing obligations arising from institutional circumstances such as security  
12 requirements or law enforcement involvement.

13

14 In response to the directive in D-345.970(3), the Council on Ethical and Judicial Affairs (CEJA) is  
15 studying these issues to determine whether additional guidance in the AMA *Code of Medical*  
16 *Ethics* is warranted. A forthcoming Council report will examine the ethical considerations  
17 associated with the treatment of persons in legal custody.

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

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1 At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a  
2 detailed explanation of its judicial function. This undertaking was motivated in part by the  
3 considerable attention professionalism has received in many areas of medicine, including the  
4 concept of professional self-regulation.

5  
6 CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove  
7 a membership application or to take action against a member. The disciplinary process begins when  
8 a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an  
9 applicant or member is reported to the AMA. This information most often comes from statements  
10 made in the membership application form, a report of disciplinary action taken by state licensing  
11 authorities or other membership organizations, or a report of action taken by a government tribunal.

12  
13 The Council rarely re-examines determinations of liability or sanctions imposed by other entities.  
14 However, it also does not impose its own sanctions without first offering a hearing to the physician.  
15 CEJA can impose the following sanctions: applicants can be accepted into membership without any  
16 condition, placed under monitoring, or placed on probation. They also may be accepted, but be the  
17 object of an admonishment, a reprimand, or censure. In some cases, their application can be  
18 rejected. Existing members similarly may be placed under monitoring or on probation, and can be  
19 admonished, reprimanded or censured. Additionally, their membership may be suspended or they  
20 may be expelled. Updated rules for review of membership can be found at [https://www.ama-](https://www.ama-assn.org/governing-rules)  
21 [assn.org/governing-rules](https://www.ama-assn.org/governing-rules).

22  
23 Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial  
24 activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities  
25 during the most recent reporting period is presented.

APPENDIX

CEJA  
*Judicial Function  
 Statistics*

APRIL 1, 2025 – MARCH 31, 2026

<b>Physicians Reviewed</b>	<b><u>SUMMARY OF CEJA ACTIVITIES</u></b>
<b>11</b>	<b>Determinations of no probable cause</b>
<b>12</b>	<b>Determinations following a plenary hearing</b>
<b>10</b>	<b>Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing</b>

<b>Physicians Reviewed</b>	<b><u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u></b>
<b>11</b>	<b>No sanction or other type of action</b>
<b>3</b>	<b>Monitoring</b>
<b>8</b>	<b>Probation</b>
<b>2</b>	<b>Revocation</b>
<b>0</b>	<b>Suspension</b>
<b>1</b>	<b>Denied</b>
<b>0</b>	<b>Suspension lifted</b>
<b>12</b>	<b>Censure</b>

<b>Physicians Reviewed</b>	<b><u>PROBATION/MONITORING STATUS</u></b>
<b>11</b>	<b>Members placed on Probation/Monitoring during reporting interval</b>
<b>8</b>	<b>Members placed on Probation without reporting to Data Bank</b>
<b>12</b>	<b>Probation/Monitoring concluded satisfactorily during reporting interval</b>
<b>0</b>	<b>Memberships suspended due to non-compliance with the terms of probation</b>
<b>30</b>	<b>Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues</b>
<b>9</b>	<b>Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues</b>

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

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1 At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the  
2 recommendations of Council on Ethical and Judicial Affairs Report 01-I-25, “Amendment to  
3 Opinion 1.1.1 “Patient-Physician Relationships.” The Council issues this Opinion, which will  
4 appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical*  
5 *Ethics*.

6  
7 E-1.1.1 – Patient-Physician Relationships

8  
9 The practice of medicine, and its embodiment in the clinical encounter between a patient and a  
10 physician, is fundamentally a moral activity that arises from the imperative to care for patients  
11 and to alleviate suffering. The relationship that emerges between a patient and a physician must  
12 be based on trust. The physician’s obligation to be trustworthy entails additional ethical duties  
13 such as a commitment to act for the good of patients; to uphold respect for patients as persons;  
14 to develop good communication skills; and to be professionally competent. This trust is  
15 fostered by physicians’ ethical responsibilities to place patients’ welfare above the physician’s  
16 own self-interest or obligations to others, to use sound medical judgment on patients’ behalf,  
17 and to advocate for their patients’ welfare. When external influences negatively impact this  
18 trust, or the patient-physician relationship directly, physicians individually and collectively  
19 should advocate for changes to ameliorate the situation and promote a more hospitable  
20 environment in which patient-physician relationships may flourish.

21  
22 A patient-physician relationship commences when a physician begins to serve a patient’s  
23 medical needs. The contexts that may lead to a patient-physician relationship vary: they  
24 generally occur as a response to a request by a patient or a patient’s surrogate, but can also  
25 include certain contractual, legally mandated, or emergency settings without the explicit  
26 request or consent of the patient.

27  
28 While the patient-physician relationship may involve one patient and one physician in today’s  
29 complex health care system, such relationships often involve multiple members of a care team,  
30 patient family members and surrogates. The core values of the patient-physician relationship,  
31 however, remain unchanged. How these values are implemented will depend on many factors,  
32 including the setting, the needs of the patient, the duration of the relationship, and the training,  
33 expertise, and experience of the physician, and will necessarily reflect the myriad ways that

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\* 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.

1 patients and physicians interact. While every patient-physician relationship will be different  
2 and will change over time, the fundamental importance of establishing and sustaining trust  
3 through respect for persons, good communication, and professional competency will always be  
4 crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore,  
5 to uphold these values and support patients and the primacy of the patient-physician  
6 relationship to the best of their ability in all practice settings and at all times. (I, II, III, V, VI,  
7 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

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1 At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the  
2 recommendations of Council on Ethical and Judicial Affairs Report 03-I-25, “Ethical Impetus for  
3 Research in Pregnant and Lactating Individuals.” The Council issues this Opinion, which will  
4 appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical*  
5 *Ethics*.

6  
7 E-7.3.4.1 Research Involving Pregnant and Lactating Individuals

8  
9 Research involving pregnant and lactating individuals, including but not limited to, research  
10 regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses  
11 or nursing infants, must balance the health and safety of individuals who participate and the  
12 well-being of their fetuses or nursing infant against the desire to develop new and innovative  
13 therapies. Although it is important to carefully consider potential fetal risks involved when  
14 pregnant and lactating individuals participate in research, it is critical to realize that large scale  
15 exclusion from participation by these individuals has also precluded potential benefits and in  
16 some cases resulted in harm for this group. The paucity of data on safe and effective medical  
17 treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing  
18 between pursuing medical interventions with uncertain risks to themselves and their fetuses or  
19 nursing infants, or foregoing the interventions altogether, which might itself cause harm due to  
20 undertreatment of medical conditions.

21  
22 Understanding both the potential risks of participation and of non-participation, physicians  
23 conducting research must obtain the informed, voluntary consent of pregnant or lactating  
24 individuals, and adhere to general principles for ethical conduct of research as in all human  
25 participant's research. In addition, physicians conducting research should:

- 26  
27 (a) Include pregnant and lactating individuals in research for which they would otherwise be  
28 eligible in order to establish a greater knowledge base, produce relevant data, and promote  
29 respect for individuals.  
30  
31 (b) Consider excluding pregnant and lactating individuals only when a study poses a  
32 substantial risk of significant harm to them or their fetuses or nursing infants, and:

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\* 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.

- 1 i. specify why the research excludes pregnant and lactating individuals;
- 2
- 3 ii. seek alternative research methodologies to rectify gaps in knowledge.
- 4
- 5 (c) Where scientifically appropriate and available, base studies that include pregnant and
- 6 lactating individuals on well-designed, ethically sound, existing research with nonhuman
- 7 animals or nongravid human participants to better assess potential risks.
- 8
- 9 (d) Minimize risks to the fetus or nursing infant to the greatest extent possible, especially when
- 10 the research is not conducted primarily to investigate potential benefit for fetuses or
- 11 nursing infants, but rather for the development of important biomedical knowledge that
- 12 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 FEHBP 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.

# 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

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

4  
5 Our AMA will conduct a thorough study of the FEHBP to understand the successes and  
6 failures, strengths and weaknesses of the program and determine how the FEHBP compares  
7 with AMA policy H-165.881 to see whether it might be an appropriate model to achieve  
8 private and public health system reform, with a report back to the A-26 Meeting of our House  
9 of Delegates.

10  
11 Under Policy [H-165.881](#), our AMA will continue to actively pursue strategies for expanding  
12 patient choice in the private sector by advocating for greater choice of health plans by consumers,  
13 equal-dollar contributions by employers irrespective of an employee's health plan choice, and  
14 expanded individual selection and ownership of health insurance where plans are truly accountable  
15 to patients. This report, which is presented as information to the HOD, discusses the FEHBP and its  
16 advantages, limitations, and consistency with AMA health reform policy.

## 17 18 BACKGROUND

19  
20 The FEHBP provides health insurance coverage to approximately 8.2 million civilian federal  
21 workers, retirees, and their dependents, or roughly 2.4 percent of the U.S. population.<sup>1</sup> As such, it  
22 is the largest employer-sponsored insurance (ESI) program in the country.<sup>2</sup> Established in 1960, in  
23 an era when many large private employers had begun offering health benefits, the intent of the  
24 FEHBP was to provide better benefits to federal employees, help them understand and compare  
25 plan options, and organize annual enrollment.<sup>3</sup>

26  
27 Administered by the U.S. Office of Personnel Management (OPM), the FEHBP is governed by  
28 [federal law](#) that authorizes OPM to contract with qualified health insurers to offer a variety of plan  
29 types, primarily including fee-for-service (FFS) plans (most of which have a preferred provider  
30 organization [PPO] component), health maintenance organization (HMO) plans, and high-  
31 deductible health plans.<sup>4</sup> Similar to other private health plans, FEHBP offerings must comply with  
32 Affordable Care Act (ACA) benefits rules and requirements regarding minimum essential benefits,  
33 prohibitions on annual and lifetime limits, and other consumer protections enshrined in the 2010  
34 law. Even so, the FEHBP is subject to fewer Department of Health and Human Services  
35 regulations than ACA marketplace, Medicare, or Medicaid plans and likewise receives less  
36 attention from Congress, interest groups, and health policy stakeholders.<sup>5</sup>

37  
38 The basic rules of the FEHBP are outlined in federal statute and regulations, which give OPM  
39 relatively broad authority to administer the program and contract with plans.<sup>6</sup> In a typical cycle,  
40 OPM sends a “call letter” to insurers in the spring and then meets with each carrier to negotiate

1 premiums, benefits, and payments for the next plan year.<sup>7</sup> The administrative structure of the  
2 FEHBP has been described as “diffuse,” in that OPM works in coordination with the many health  
3 plans with which it contracts as well as more than a hundred federal agency employment offices.<sup>8</sup>  
4 Enrollment in the FEHBP is managed by federal agency personnel offices that oversee  
5 participation in accordance with OPM rules and procedures. The intent is to help workers enroll in  
6 coverage; unlike other federal health programs, OPM as the administrator does not engage in  
7 public purchasing or provider rate setting.<sup>9</sup>

8  
9 Like other types of ESI, both the federal government and enrollees contribute towards the costs of  
10 FEHBP coverage. The federal government’s share of premiums, known as the “fair share” formula  
11 and governed by statute, is intended to keep federal contributions consistent, regardless of the plan  
12 selected by an employee.<sup>10</sup> Generally, the government pays about 72 percent of the average  
13 premium across all plans (sometimes more, sometimes less) and will pay no more than 75 percent  
14 of a particular plan’s premium.<sup>11</sup>

15  
16 Premiums are designed to cover health care costs, plans’ administrative expenses and profits, and  
17 OPM’s administrative costs.<sup>12</sup> In reviewing health plans to be offered under the FEHBP, OPM  
18 considers the ability of plans to provide reasonable access to and choice of primary and specialty  
19 medical care throughout the service area. Participating health plans must be open to all workers,  
20 and no one can be denied coverage due to pre-existing conditions. OPM policy states that all  
21 participating carriers must be committed to the following:

- 22  
23 1. Ensuring enrollees have access to good health care benefits;  
24 2. Striving to keep premiums affordable;  
25 3. Ensuring enrollees have access to quality provider networks;  
26 4. Providing competitive health care choices for consumers;  
27 5. Strengthening information for consumers so they can be more involved and responsible for  
28 their own health care decisions;  
29 6. Being well managed and financially secure;  
30 7. Providing efficient and effective contract administration;  
31 8. Ensuring the timely and accurate submission of actuarial data and financial accounting  
32 information;  
33 9. Maintaining compliance with laws, regulations, contract requirements and administrative  
34 guidance at all times; and  
35 10. Guaranteeing that enrollee and government resources are protected.<sup>13</sup>

36  
37 Importantly, eligibility for the FEHBP is limited to civilian federal employees, federal retirees,  
38 White House staff, and cabinet members. Per the ACA, members of Congress and their staffs are  
39 required to purchase coverage through an ACA exchange in order to receive a government  
40 contribution. Similar to other ESI programs, FEHBP-eligible individuals can enroll themselves and  
41 their family members in FEHBP plans within 60 days of being hired; during an open enrollment  
42 period; or within a specific timeframe of experiencing a qualified life event, such as a marriage,  
43 divorce or the birth or adoption of a new baby.<sup>14</sup> According to OPM, the FEHBP enrollee  
44 population reflects the demographics of the federal workforce: the median age of active employees  
45 is 47; approximately 42 percent of enrollees in the FEHBP and Postal Service Health Benefits  
46 Program are over the age of 50; and around 11 percent are younger than 30. When retiree  
47 demographics are considered together with the active workforce, the average age of FEHBP  
48 enrollees is around 60.<sup>15</sup>

1 Advantages of the FEHBP

2  
3 Policy D-185.906 directed the AMA to study the successes and strengths of the FEHBP, which we  
4 describe as “advantages.” For decades, the FEHBP has been viewed by many as a highly successful  
5 program. When compared to other types of coverage, its advantages include the following:

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

16  
17 *Comprehensive benefits package and patient protections:* Most FEHBP plans offer comprehensive  
18 coverage, including preventive services at no cost when received from a preferred provider.  
19 Notably, GLP-1 medications are currently covered by FEHBP. Additionally, there are no waiting  
20 periods or coverage restrictions based on pre-existing conditions.

21  
22 *Generous federal contributions:* Federal contributions towards FEHBP plans are not based on  
23 employee income. Rather, the federal government pays 72 to 75 percent of the average premium  
24 across all plans with employees responsible for the remainder. In comparison, according to KFF’s  
25 Employer Health Benefits Survey (which includes data from both public and private employers) in  
26 2025 employers contributed on average 84 percent of single coverage premiums and 74 percent of  
27 family plan premiums.<sup>21</sup>

28  
29 *Continuity of coverage:* Unlike most private employer plans, the FEHBP provides continuity of  
30 coverage to federal workers and retirees. FEHBP enrollees are able to maintain their coverage  
31 when transitioning to other federal jobs/agencies, and can continue FEHBP coverage into  
32 retirement. Because many private employers no longer offer retiree health coverage, continuity of  
33 coverage into retirement should be considered a particularly valuable FEHBP perk.

34  
35 *Less attention from Congress, regulators:* Unlike other federal health programs, the FEHBP is  
36 somewhat insulated from policymakers and stakeholders and receives less attention from Congress  
37 and regulators than other federal health programs. In Congress, the program falls under the  
38 jurisdiction of the House Oversight and Accountability Committee and Senate Committee on  
39 Homeland Security and Government Affairs instead of the health and tax committees that oversee  
40 most Congressional health care matters.

41  
42 Limitations of the FEHBP

43  
44 Limitations of the FEHBP include the following:

45  
46 *High and Increasing costs:* The main shortcoming of the FEHBP is that its health coverage is  
47 expensive, and costs are rising. In 2026, employees and retirees are expected to contribute 12.3  
48 percent more, on average, towards their premiums after incurring a 13.5 percent increase in  
49 premium contributions in 2025.<sup>22</sup> The average premium increase overall in 2026 is 10.2 percent,  
50 down from 11.2 percent in 2025, while the federal contribution increased 9.2 percent in 2026,  
51 down from 10.1 percent in 2025.<sup>23</sup> The program’s recent double-digit increases may generally be

1 higher than premium cost increases at many private firms, whose average premium contributions  
 2 vary by firm size, industry, and other factors.

3  
 4 OPM has stated that premium increases this year are due in part to an aging workforce; the use of  
 5 expensive prescription medications, especially GLP-1 drugs; and increased behavioral health  
 6 spending.<sup>24,25</sup> Health policy experts have also highlighted higher hospital prices as a contributor.<sup>26</sup>  
 7 OPM states that it routinely compares FEHBP premium costs to other large employers, although  
 8 detailed benchmarking was not included in its benefits highlights for the current plan year. In last  
 9 year’s benefits highlights, OPM asserted that the FEHBP’s overall average premium increase (11.2  
 10 percent) was similar to premium increases at comparable large employers, citing the California  
 11 Public Employees’ Retirement System—the second largest purchaser of public employee health  
 12 benefits (after the federal government)—which saw average premiums increase by 10.8 percent.<sup>27</sup>  
 13 OPM also cited the Large Employer Health Strategy Survey, conducted by the Business Group on  
 14 Health, which found that large employers projected an average premium increase of eight percent  
 15 for plan year 2025.<sup>28</sup>

16  
 17 *Limited eligibility:* An obvious but important drawback of the FEHBP as a reform model is its  
 18 eligibility parameters, which limit enrollment to federal employees and retirees and their  
 19 dependents, thus ensuring the overall stability of its risk pool.

20  
 21 *Choice overload:* Too much choice and not enough information to help guide enrollee decision-  
 22 making may make it difficult for some federal employees to understand how different plans could  
 23 impact their costs and access to care. Choice overload has also been cited as a challenge in other  
 24 insurer markets, including ACA exchanges.

25  
 26 *Susceptibility to changes in administration priorities:* Given the White House’s oversight of federal  
 27 agencies, including OPM, the FEHBP may be more susceptible to changes intended to align the  
 28 program with administration priorities. For example, coverage for some gender-affirming care for  
 29 people of all ages was removed from the FEHBP following an executive order by President  
 30 Trump.<sup>29</sup>

31  
 32 **ROLE OF THE FEHBP IN HEALTH REFORM EFFORTS**

33  
 34 Various health reformers have pointed to the FEHBP as a model almost since its inception,  
 35 although considerations of the program were more frequent during the pre-ACA era and less so in  
 36 recent years. Of note, proposals from across the political spectrum have been based in part on the  
 37 FEHBP’s framework, including the *Healthy Americans Act*—proposed in 2007 and 2009 by  
 38 Senators Wyden and Bennett to establish universal health care—and the *FEHBP for All Act*, first  
 39 introduced in 2011 by Representative Darrell Issa to repeal the ACA and open up the FEHBP to  
 40 everyone. Importantly, the Issa bill kept the traditional FEHBP program intact to prevent adverse  
 41 selection from negatively affecting the risk pool.

42  
 43 *The FEHBP as a Model for National Health Insurance*

44  
 45 In the 1990s, calls for the public to be able to purchase the same health coverage as members of  
 46 Congress, who prior to the ACA were typically enrolled in the FEHBP, led to an array of proposals  
 47 to open the FEHBP to the public and treat it as national health insurance. Back then, the FEHBP  
 48 was widely praised as providing excellent coverage at low administrative cost. Not surprisingly,  
 49 federal employees and their unions vehemently opposed such legislation, which they believed  
 50 would significantly increase their premium costs. Moreover, the complexities involved in  
 51 implementing such proposals became apparent when, for example, the OPM director at the time

1 commented that the FEHBP is “a wonderful working model, but it cannot be instantly  
 2 duplicated.”<sup>30</sup> More modest proposals to open the FEHBP to uninsured people and/or small  
 3 businesses were also debated, and President Clinton’s health package—released in 1995—included  
 4 a provision allowing small businesses to buy into the program.<sup>31</sup>

5  
 6 *The FEHBP as a Model for Restructuring Medicare*

7  
 8 Also in the 1990s, several proposals to restructure the Medicare program based in part on the  
 9 FEHBP were considered by various stakeholders because, at that time, the FEHBP was viewed as  
 10 more successful than Medicare at controlling spending while offering robust choice and achieving  
 11 high participant satisfaction.<sup>32</sup> In 1995, Stuart Butler and a colleague from the Heritage Foundation  
 12 proposed reforming Medicare by adopting the FEHBP’s choice and competition features and by,  
 13 among other things, transforming it from an entitlement to a defined contribution program (though  
 14 the FEHBP is not strictly a defined contribution model) and providing vouchers that enrollees  
 15 could put towards a private plan of their choosing.<sup>33</sup> A few years later, a provision in the Balanced  
 16 Budget Act of 1997, called Medicare+Choice, established Medicare Part C by authorizing the  
 17 participation of private plans, thus launching the initial phase of what is now known as Medicare  
 18 Advantage (MA).<sup>34</sup> The Medicare Modernization Act of 2003 further modified plan payments in  
 19 Part C and established the Part D prescription drug program, which also incorporated the FEHBP’s  
 20 “managed competition” structure.<sup>35,36</sup>

21  
 22 *The FEHBP as a Model for the ACA, Public Option Proposals*

23  
 24 The idea of the FEHBP as a model for national health insurance was also debated in the years  
 25 leading up to passage of the ACA, although some analysts cautioned against opening it up to non-  
 26 federal workers in order to prevent disrupting the program’s stable risk pool. In the end, President  
 27 Obama rejected calls to open the FEHBP to the public in favor of carefully-designed insurance  
 28 exchanges.<sup>37</sup>

29  
 30 The ACA also adopted some protections that had previously been provided to FEHBP enrollees,  
 31 such as the prohibition on coverage restrictions based on health status. In 2009, a spinoff of the  
 32 FEHBP that would authorize OPM with overseeing national health plans (outside of the FEHBP)  
 33 was discussed as a potential replacement for the public option that was included in legislation  
 34 passed by the House of Representatives. However, neither a public option nor an FEHBP spinoff-  
 35 type option was included in the Senate bill or final ACA package.

36  
 37 Leveraging health plan FEHBP participation to address counties lacking individual market insurers  
 38 (known as bare counties) was a key component of a bipartisan proposal to improve the ACA in  
 39 2017. This proposal would have required, as a condition of continued participation in the FEHBP,  
 40 the two largest FEHBP insurers in a county to offer at least one silver plan through the federal  
 41 exchange in all counties that would otherwise be bare.

42  
 43 In an effort to build upon the ACA’s existing structure, a new coverage option for exchanges that  
 44 would allow the public to enroll in the FEHBP has also been suggested.<sup>38</sup> Perhaps due to feasibility  
 45 and/or cost concerns as well as existing FEHBP eligibility restrictions, such proposals have not  
 46 gained much traction. Instead, most proposals put forward in Congress to establish a public option  
 47 on ACA exchanges have been tied to Medicare or Medicaid payment rates in order to keep costs  
 48 down, since the intent of a public option is to offer good coverage that costs less than other  
 49 competing plans. Likewise, at the time this report was written, none of the states implementing a  
 50 public option had adopted an approach that would allow the public to enroll in either the FEHBP or  
 51 state employee health plan. Instead, public option laws in Washington, Colorado, and Nevada aim

1 to lower premiums and decrease overall health costs by either capping provider payments  
 2 (Washington), establishing premium reduction targets (Nevada), or both—setting premium targets  
 3 with the authority to reduce provider payments if the targets are not met (Colorado).<sup>39</sup> Several other  
 4 states have considered various public option proposals and may, in the future, explore leveraging  
 5 their state’s employee benefits plan to increase available exchange plan offerings.

6  
 7 AMA POLICY

8  
 9 Longstanding policy (Policy [H-165.846](#)) has supported using federal guidelines, such as those  
 10 under the FEHBP, as a standard for assessing meaningful health insurance coverage. As previously  
 11 noted, Policy [H-165.881](#) states that our AMA will continue to actively pursue strategies for  
 12 expanding patient choice in the private sector by advocating for greater choice of health plans by  
 13 consumers, equal-dollar contributions by employers irrespective of an employee's health plan  
 14 choice, and expanded individual selection and ownership of health insurance where plans are truly  
 15 accountable to patients. Additional policies referencing the FEHBP include:

- 16  
 17 • Policy [H-165.825](#), which supports requiring the largest two FEHBP insurers in counties that  
 18 lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of  
 19 FEHBP participation. To clarify, this policy would not allow individuals to buy-in to FEHBP  
 20 plans. Rather, individuals in otherwise bare counties would have the choice of at least two  
 21 silver plans that abide by ACA requirements, offered by the two largest FEHBP insurers in  
 22 their county.  
 23  
 24 • Policy [H-180.961](#), which encourages the National Association of Insurance Commissioners to  
 25 develop standards and a uniform disclosure format applicable to health plans and policies  
 26 offered in the general insurance market, taking into consideration the benefit definitions and  
 27 disclosure format used by plans participating in the FEHBP.

28  
 29 Policies addressing ESI, including Policies [H-165.828](#) and [H-165.843](#), are also relevant to the  
 30 FEHBP as it is the largest ESI provider in the country. For decades, AMA policy has advocated for  
 31 the promotion of individually selected and owned health insurance using refundable and  
 32 advanceable tax credits that are inversely related to income so that patients with the lowest incomes  
 33 receive the largest credits (e.g., Policies [H-165.920](#) and [H-165.865](#)). Additional AMA health  
 34 reform policies relevant to this report include:

- 35  
 36 • Policy [H-165.838](#), which states that insurance coverage options offered in a health insurance  
 37 exchange should be self-supporting; have uniform solvency requirements; not receive special  
 38 advantages from government subsidies; include payment rates established through meaningful  
 39 negotiations and contracts; not require provider participation; and not restrict enrollees’ access  
 40 to out-of-network physicians. This policy further commits the AMA to achieving health  
 41 reforms that include numerous components, including health insurance coverage for all  
 42 Americans; insurance market reforms that expand choice of affordable coverage and eliminate  
 43 denials for pre-existing conditions; and assurance that health care decisions will remain in the  
 44 hands of patients and their physicians, not insurance companies or government officials.  
 45  
 46 • Policy [H-165.823](#), which advocates for a pluralistic health care system—which may include a  
 47 public option—that focuses on increasing equity and access, is cost-conscious, and reduces  
 48 burden on physicians. This policy establishes standards for supporting a public option and for  
 49 supporting auto-enrollment in health insurance coverage.

- 1 • Policy [H-165.985](#), which reaffirms core AMA health reform principles, including free market  
2 competition; freedom of patients to select and change physicians or health plans; freedom of  
3 physicians to choose whom they will serve, to establish their fees at a level which they believe  
4 fairly reflect the value of their services, and to participate or not participate in a particular plan  
5 or method of payment; and full and clear information to consumers on the provisions and  
6 benefits offered by alternative medical care and health benefit plans, so that the choice of a  
7 source of medical care delivery is an informed one.  
8

## 9 DISCUSSION

10  
11 Although the FEHBP has often been cited as a model for providing robust health plan competition  
12 and choice at reasonable cost, the Council finds that expanding the program broadly is not a viable  
13 strategy for increasing coverage and patient choice. Proposals incorporating the FEHBP in health  
14 system reforms have diminished in recent years, possibly due to the availability of exchange plan  
15 coverage under the ACA and/or because the FEHBP is less competitive and more costly than it  
16 once was. In comparing the FEHBP to other types of coverage, the Council found that the structure  
17 of the FEHBP does not substantially differ from the ACA marketplace or large employer plans,  
18 though the catalog of FEHBP plan options may be larger in some areas, its risk pool may be more  
19 stable than that of the ACA market, and FEHBP coverage may be continued into retirement. Unlike  
20 the 1960s when the FEHBP was created, most health plans must now meet certain standards and  
21 requirements, which has narrowed the differences between the FEHBP and other coverage types.  
22

23 FEHBP consumer protections and benefit packages are generally comprehensive, as evidenced by  
24 the FEHBP's coverage of GLP-1 medications for obesity; however, they are not necessarily more  
25 generous than some large private employer offerings. In terms of cost, true comparisons between  
26 the FEHBP and other types of coverage would require detailed analysis at the local level; however,  
27 the Council points to recent double-digit increases in federal worker premium costs. Of note, the  
28 Council also recognizes that significant federal workforce reductions since 2025 may impact the  
29 FEHBP as soon as next year in ways that are not yet understood. For example, it is not clear how  
30 the FEHBP risk pool will be affected and whether some carriers may opt to exit the program in  
31 areas like Washington, DC that have experienced substantial decreases in staffing.  
32

33 The Council believes that the FEHBP is largely consistent with Policy [H-165.881](#) as well as AMA  
34 policies emphasizing pluralism, choice, competition, and other essential health reform principles.  
35 In particular, the FEHBP provides a broad array of competing plan options and a standardized  
36 employer contribution, both of which encourage consumer choice and plan competition. That said,  
37 we do not necessarily view the FEHBP as the most promising solution to achieving universal  
38 coverage, primarily due to its limited eligibility and rising costs. Additionally, premium  
39 contributions for federal workers are not tied to their household incomes; rather, the federal  
40 government pays between 72 and 75 percent of worker premiums, amounts that do not increase or  
41 decrease based on income. This feature of the FEHBP could be viewed as inconsistent with AMA  
42 policy advocating for the use of tax credits that are inversely related to income, so that patients  
43 with the lowest incomes receive the largest credits.  
44

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

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

8  
9 CONCLUSION

10  
11 Having decided against recommending new AMA policy supportive of expanding eligibility for the  
12 FEHBP to non-federal workers—which would threaten that program’s sustainability—the Council  
13 did not identify gaps in existing AMA policy that would preclude assessment of future reform  
14 proposals that are based in part or in full on the FEHBP. Therefore, the Council makes no policy  
15 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)