Reference Committee A

Report(s) of the Board of Trustees

23 Liberalized Remorse Period for Medicare Advantage Plan Insureds

Report(s) of the Council on Medical Service

03 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
05 Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
08 Rural Health Transformation Program Update & Workforce Challenges

Resolutions

101 Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01"Morbid (Severe) Obesity Due to Excess Calories"
102 Study for EMTALA Relief in Psychiatric Facilities
103 Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
104 Improving Choice, Competition, and Affordability in the ACA Marketplaces
105 Oppose Medicare Advantage Auto Enrollment
106 Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
107 Oversight of Medicare Advantage Plan
108 Ensuring Physician Input in the Development of CMMI Models
109 Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy
110 Medicaid Coverage for Incarcerated Individuals
111 Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia
112 Ensuring Coverage and Access to Adult Strabismus Surgery
113 Health Insurance Coverage of Hearing Devices and Related Services
114 Opposing Alternative Funding Programs
115 Patient Continuity Protections During Payer, PBM Changes
116 Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs
117 Universal Out of Network Benefits
118 Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

REPORT OF THE BOARD OF TRUSTEES

BOT Report 23-A-26

Subject: Liberalized Remorse Period for Medicare Advantage Plan Insureds

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee A

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

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

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

BACKGROUND

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

In addition to these two standard enrollment periods, there are Special Enrollment Periods for which beneficiaries can become eligible due to many reasons. These include whether the beneficiary moves or their circumstances change, such as admission to or discharge from a nursing facility. They also include coverage changes such as losing Medicaid eligibility or being offered coverage from a union or employer, as well as plan changes such as the plan ending its Medicare contract or CMS ending its contract with the plan or sanctioning the plan. Other factors that make beneficiaries eligible for a Special Enrollment Period

are if they are in an MA plan with a relatively low star rating and/or want to enroll in a five-star plan, as well as if their choice was based on bad information. Other important reasons that beneficiaries can change their Medicare coverage are if there is a significant change in the plan's provider network or if they chose their MA plan based on incorrect information about the network. For example, CMS recently adopted an AMA recommendation that MA plans include their physician directories on the Medicare Plan Finder. The agency then determined that beneficiaries who choose a plan based on incorrect information in the Medicare Plan Finder about their physician being in-network are eligible for a Special Enrollment Period.

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

AMA POLICY

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

DISCUSSION

Beneficiaries do not receive clear and objective information about the Medicare program and how to choose their Medicare coverage, either when they initially become eligible for the program or during the Medicare Annual Enrollment Period. They may choose to enroll in an MA plan without knowing what it means to have a network, whether their physician(s) is in the plan's network, or whether the network will be able to offer the types of care they may need at a location and cost that is accessible to them. Many beneficiaries who choose MA believe they will have lower out-of-pocket costs in MA. Although this is possible as MA plans have out-of-pocket spending limits that traditional Medicare does not, the limits can be as high as $9,250 for in-network services and $13,900 for combined in- and out-of-network services. Beneficiaries with a Medigap supplemental policy may not understand that they cannot use their Medigap coverage for copayments once they enroll in MA, nor that the MA cost-sharing for services like chemotherapy could be just as expensive in MA as in regular Medicare Part B. Most tests, referrals, admissions, procedures, and therapies are available in traditional Medicare without prior authorization, but prior authorization requirements are pervasive in MA. (There is prior authorization for many medications whether patients are in MA or in traditional Medicare with a standalone Part D prescription drug plan.)

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

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

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

RECOMMENDATIONS

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

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

Fiscal note: Less than $500

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates referred Resolution 113-A-25, which asks that the American Medical Association (AMA) support efforts to expand telepharmacy, advocate for equitable pharmacy reimbursement, and study the impact of preferred pharmacy networks with the goal of mitigating access issues for patients in pharmacy deserts.

The Council on Medical Service reviewed information on the current state of pharmacies across the United States and the elements involved in their ability to succeed. Currently, pharmacies are facing a closure crisis, leading to many communities being deemed "pharmacy deserts," or areas in which residents do not have adequate access to a pharmacy. Pharmacies face a number of issues in remaining financially viable. Low reimbursement rates from payers are often driven by pharmacy benefit manager (PBM) negotiations resulting in rates that do not cover the full acquisition and operating costs associated with a drug. Further, many PBMs are vertically integrated with payers and/or large chain pharmacies leading to a highly concentrated market and, often, resulting in anticompetitive practices or PBMs excluding small/community pharmacies from preferred pharmacy networks. The Council reviewed the literature and considered a variety of information on a number of potential solutions to support pharmacies and reduce pharmacy deserts. First, the Council reviewed alternative dispensing methods, such as telepharmacy, remote dispensing, and mail order dispensing. Both telepharmacy and remote dispensing allow patients who cannot access a full-service pharmacy to access pharmacist services via the internet. Further, mail order pharmacy services allow patients, especially those with managed chronic conditions, to receive a convenient supply of medication delivered to their home. Although these types of prescription dispensing have been shown to be beneficial to patients and pharmacies, challenges remain when there is not reliable access to broadband, patients lack safe mail delivery methods, and the prescription is not shelf-stable or is needed urgently. Second, the Council explored legislative and regulatory solutions, including PBM regulation and boosted reimbursement rates. These types of regulations have shown promise, especially at the state level, in ensuring pharmacies receive reimbursement adequate for operations and limiting untoward PBM practices. Finally, the Council reviewed federal, state and non-governmental incentive-based solutions. Similar to programs designed to attract physicians to underserved areas, these programs are designed to make operating a pharmacy in an underserved area more possible and, in some cases, advantageous for pharmacists.

Based on its review of the issue, the Council recommends the adoption of new AMA policy that supports efforts to ensure that pharmacy reimbursement rates are adequate to cover the actual costs related to obtaining and dispensing medications. The Council also recommends policy that supports the establishment of a minimum preferred pharmacy network adequacy standard and recognizes and encourages payer coverage of telepharmacy and remote dispensing when specific criteria are met. Furthermore, the Council recommends new policy that supports payer and PBM practices that promote fair market competition, patient choice, and support the financial viability of independent and community pharmacies. In addition to new policies, the Council recommends the reaffirmation of Policy H-120.989, which outlines appropriate mail order pharmacy practices and recognizes it as a legitimate drug dispensing method, and Policy D-110.987, which outlines advocacy efforts related to PBM regulation towards increased transparency.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-26

Subject: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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

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

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

BACKGROUND

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

These closures highlight an overarching trend among not only chain pharmacies, but also local/independent pharmacies. Estimates show that independent pharmacies make up about 35 percent of all pharmacies nationally and meet the needs of over 15 million Americans.[5] These pharmacies are also closing rapidly, approximately one per day.[5] Historically, independent community pharmacies have closed at a higher net rate than chain pharmacies. However, in recent years more independent pharmacies have also been opening, which has lowered their net closure

rate. This more recent trend may indicate that independent pharmacies have a higher "churn rate," meaning that while they may open more frequently, they are unable to stay in business and end up closing or selling to a chain. Notably, while there is an increase in independent pharmacies opening, they do not seem to be opening in communities that are low-income or which currently lack access to pharmacies.[6,7] This is particularly important as research demonstrates that individuals who live in rural areas, are 65 years or older, or live in a low-income household are more likely to rely on independent pharmacies for access to prescriptions.[8] As these pharmacies often lack the bargaining power that bigger chain pharmacies have, they may struggle to stay open, exacerbating the access problems within vulnerable communities.[7]

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

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

PHARMACY ECONOMICS

Prior to the modern insurance paradigm, pharmacy economics were straightforward, as pharmacists acquired the goods and set prices based on supply and demand. Pharmacies buy a drug at a price set by the drug manufacturer and the consumer purchases it with the markup determined by the pharmacy. However, with the advent of prescription drug insurance, the patient-pharmacist connection became less direct as payers were inserted in the middle, shifting pharmacist focus to volume to keep pharmacies economically viable.[15] The inception of the Medicare Modernization Act in 2003, which created Medicare Part D and the contemporary business model used by pharmacy benefit managers (PBMs), further complicated pharmacy reimbursement and what was necessary to stay in business.[15] Payment paradigms become increasingly complicated when payers, PBMs, and discount programs are involved in the transaction.[16,17] If a patient is utilizing insurance, the plan typically pays for the bulk of a covered drug at the set reimbursement rate with the pharmacy, usually negotiated by a PBM. Often the patient is responsible for some out-of-pocket (OOP) payment that is paid directly to the pharmacy. In theory, the combination of the patient OOP payment and the payer reimbursement should cover the drug and dispensing costs for the pharmacy. However, in practice, pharmacy reimbursement does not fully cover acquisition and operating costs.[17] Moreover, another concerning issue arises when a non-integrated pharmacy deals with a PBM that is vertically integrated as it can result in anticompetitive practices.[18,19] Several mergers and acquisitions across the pharmacy and PBM/payer markets, as well as insurers creating their own PBMs, have led to large vertically integrated firms operating across these three product markets.[20] Estimates show that five of the six largest PBMs are vertically integrated with both insurers and pharmacies, indicating high concentration in PBM markets.[19,21] Research shows that nearly 80 percent of prescription claims are processed by the three largest PBMs.[17,18]

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

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

price much lower than most other pharmacies can offer, which they can then sell at rates significantly lower than non-340B pharmacies or at more favorable markups.[21]

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

POTENTIAL SOLUTIONS

Pharmacy-Based Solutions

There are a number of potential pharmacy-based solutions that could work towards improving pharmacy access and, since no solution will independently fix the entirety of the problem, it is important to explore them together. One such potential solution, particularly in existing pharmacy deserts, is the expansion of telepharmacy, which generally consists of a remote pharmacist providing traditional services, such as prescription review, prescription verification, and patient consultation, via the internet.[26] Individuals who do not have convenient access to a pharmacy or may not be able to travel to a pharmacy could benefit most from telepharmacy services. In practice, telepharmacy has shown promise in addressing access issues and reducing operating costs, as they operate with increased efficiency.[27] This has shown improved patient outcomes and medication adherence while reducing unnecessary medical visits and hospitalizations.[28]

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

Further, mail order pharmacy services are another potential part of the solution. While similar to telepharmacy and remote dispensing, mail order pharmacy services do not always entail real-time interaction between the patient and pharmacists.[32] These services are typically operated through a patient's PBM and mail prescriptions directly to the patient's home. While there can be variety in medications provided, the vast majority of mail order prescriptions are sent as a 90-day supply, thus making this method of delivery most appropriate for well-managed chronic conditions and/or maintenance medications and not as useful for acute prescription needs, like an antibiotic.[32] While there are clear potential benefits to the expansion of telepharmacy, remote dispensing, and mail-order pharmacy services, there are also significant barriers. Communities that are more likely to be in a pharmacy desert are also less likely to have access to reliable broadband as there are significant disparities in access to broadband in rural communities and in majority Black and Hispanic neighborhoods.[33,34] Additionally, the necessary technological investment, both initially and ongoing, can be overwhelming for many pharmacies. Telepharmacy services require significant technological infrastructure and security which is complex and can be prohibitively expensive.[28] Of note, while not a required aspect, many of these solutions include an enhanced clinical role for pharmacists.[27] The AMA has long opposed scope of practice expansions that would allow pharmacists to practice medicine—which includes making a diagnosis or prescribing medications—without appropriate physician supervision.[35]

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

Legislative & Regulatory Solutions

At a minimum, pharmacies must be reimbursed in a manner that allows them to remain open and accessible in communities across the United States. It is essential that payers reimburse pharmacies in a manner that is fair and covers the actual costs of obtaining and dispensing the medication. Similar to physician practices that dispense medications, it is not possible for pharmacies to provide medications at a deficit and remain financially viable.[23] To ensure that reimbursement is

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

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

Incentive Based Solutions

In addition to regulatory or legislative solutions, some states have worked to provide pharmacies serving underserved communities with monetary support via grants. For example, Illinois offers the Pharmacy Support Program to pharmacies serving underserved areas in an effort to improve access to pharmacies and pharmacy services. Further, private organizations and associations have stepped in to provide support and funds for pharmacies operating in pharmacy deserts. For example, the National Community Pharmacists Association announced the Rural Pharmacy Ownership

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

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

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

AMA POLICY AND ADVOCACY

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

In addition to mail and internet-based pharmacies, the AMA has extensive policy to ensure that patients have access to the medications prescribed by their physician without interference from payers or PBMs. Policies H-110.991, H-110.990, and H-110.959 are all designed to ensure that patients have timely and affordable access to the medications as prescribed by their physician. Policy H-120.943 outlines AMA efforts to ensure that patients have access not only to affordable medications, but also quantities that are adequate and do not face arbitrary limits. To combat harmful PBM practices, Policies D-120.988, H-120.924, and H-110.963 limit PBM and payer

intrusion in prescription access, increase transparency, and hold these bodies accountable should patient harm occur. Policy H-125.986 outlines the importance of ensuring that payment for prescriptions is adequate to cover the full cost of prescription medications for both pharmacies and physicians/physician practices. Policy D-160.920 outlines efforts to track and work against the vertical integration between payers, PBMs, and pharmacies. This policy outlines efforts to communicate concerns and advocate for change with federal and state legislators and regulators. To further combat poor PBM practices, Policy H-110.957 outlines AMA opposition to spread pricing and discusses efforts to prohibit it on a federal and state level. Policy D-110.987 focuses on efforts to increase transparency in PBM practices, specifically in relation to patient impact and pharmacy payment. To support the aforementioned policies, the AMA also advocates for improved medication access and against PBM harms via the grassroots site TruthinRx. This campaign works to educate and influence patients, physicians, and legislators about harmful payer and PBM practices/policies. Additionally, efforts have been made at the state and federal levels to advocate for legislation to limit PBM and payer harmful practices. The AMA supported these federal PBM reforms as well as the health policy wins included in the Consolidated Appropriations Act of 2026.

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

DISCUSSION

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

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

line with existing network adequacy policy, this policy would work to ensure that a minimum preferred network standard be enforced across payers and bolster independent pharmacy inclusion when possible. In conjunction, these two policies could work to support existing pharmacies in continuing ongoing operations.

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

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

RECOMMENDATIONS

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

1. Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs. (New HOD Policy)

2. Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including, when possible, independent pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)

3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
    a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.
    b. Medications are delivered to patients accurately and in a timely manner.
    c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
    d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
    e. Existing community pharmacies are not displaced. (New HOD Policy)

4. Our AMA supports the development of innovative programs designed to improve access to pharmacies and the appropriate regulatory changes to allow for these programs to be implemented while ensuring high-quality, physician-led care in alignment with AMA policy. (New HOD Policy)

5. Our AMA supports practices by payers/insurers or pharmacy benefit managers (PBMs) that promote fair market competition, patient access and choice of pharmacy, and supports the financial viability of full-service independent/community pharmacies. (New HOD Policy)

6. That our AMA reaffirm Policy H-120.989, which recognizes mail order pharmacy services as legitimate method for drug distribution and outlines its appropriate use. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation. (Reaffirm HOD Policy)

Fiscal Note: Minimal

REFERENCES

1. Valliant S N, Burbage S C, Shweta P, Urick B Y. Pharmacists as accessible health care providers: quantifying the opportunity. J Man Car & Sp Ph, 28(1). doi.org/10.18553/jmcp.2022.28.1.85
2. Murphy M, Rodis J. The growing crisis of pharmacy deserts. 2025. https://pharmacy.osu.edu/news/growing-crisis-pharmacy-deserts
3. Pharmacy Deserts: Why They Matter for Your Clients and What You Can Do About It. 2025. NFP. https://www.nfp.com/insights/pharmacy-deserts-impact-and-action-steps/
4. Reilly K, Lambert M. Rite Aid shutters all stores after years of financial struggles. 2025. NBC News. https://www.nbcnews.com/news/us-news/rite-aid-closes-stores-nationwide-rcna235596
5. Hassanein N. Independent pharmacies know their communities. But many are struggling to stay open. 2025. Stateline. https://stateline.org/2025/01/17/independent-pharmacies-know-their-communities-but-many-are-struggling-to-stay-open/
6. Rodis, J. Presentation to AMA Council on Medical Service. January 2026.
7. Hernandez I, Tang S, Morales J, et al. Role of independent versus chain pharmacies in providing pharmacy access: a nationwide, individual-level geographic information systems analysis. *Health Aff Sch*. 2023;1(1):qxad003. doi:10.1093/haschl/qxad003
8. Howell, L. Independent pharmacies and those in Black and Latinx communities are most affected by pharmacy closures. 2024. American Pharmacists Association. https://www.pharmacist.com/Blogs/CEO-Blog/Article/independent-pharmacies-and-those-in-black-and-latinx-communities-are-most-affected-by-pharmacy-closures
9. Qato D, et al. 'Pharmacy Deserts' Are Prevalent In Chicago's Predominantly Minority Communities, Raising Medication Access Concerns. 2014. Health Affairs. https://doi.org/10.1377/hlthaff.2013.1397
10. Mathis WS, Berenbrok LA, Kahn PA, Appolon G, Tang S, Hernandez I. Vulnerability Index Approach to Identify Pharmacy Deserts and Keystone Pharmacies. JAMA Netw Open. 2025;8(3):e250715. doi:10.1001/jamanetworkopen.2025.0715
11. Hopper L. USC researchers reboot national pharmacy desert map amid wave of drugstore closures. 2025. https://today.usc.edu/usc-researchers-reboot-national-pharmacy-desert-map-amid-wave-of-drugstore-closures/
12. Perzigian A, Gurunathan L. Pharmacy Deserts: A Crisis Health Care Providers Can Help Solve with Technology and Teamwork. 2025. Pharmacy Times. https://www.pharmacytimes.com/view/pharmacy-deserts-a-crisis-health-care-providers-can-help-solve-with-technology-and-teamwork
13. Qato DM , Lindau ST , Conti RM , Schumm LP , Alexander GC . Racial and ethnic disparities in cardiovascular medication use among older adults in the United States . Pharmacoepidemiol Drug Saf . 2010 ; 19 (8): 834 – 42 .
14. Zhang Y , Lave JR , Donohue JM , Fischer MA , Chernew ME , Newhouse JP . The impact of Medicare Part D on medication adherence among older adults enrolled in Medicare-Advantage products . Med Care . 2010 ; 48 (5): 409 – 17
15. Mattingly TJ, Hyman DA, Bai G. Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy. JAMA Health Forum. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
16. Pharmacies Excluded from Preferred Networks Face Much Higher Risk of Closure. USC Schaeffer Center. 2025. https://schaeffer.usc.edu/research/pharmacy-networks-closures-medicare-pbms/
17. Guardado J. Policy Research Perspective: Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2025 Update. 2025. American Medical Association. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2025.pdf
18. Kuloyo O, French M. What to Know About Preferred Pharmacies with Medicare. 2025. Healthline. https://www.healthline.com/health/medicare/preferred-pharmacy
19. The Pharmacy Reimbursement Crisis. 2020. National Association of Chain Drug Stores. https://www.nacds.org/pdfs/pharmacy/2020/Pharmacy-Reimbursement-2020.pdf
20. Pharmacy Reimbursement Crisis and The Path to Sustainability. 2025. Qualify Health. https://qualify.health/blog/pharmacy-reimbursement-crisis-and-the-path-to-sustainability/
21. Joseph S. Why Pharmacies like Walgreens, Rite Aid, and Independents are Dying. 2026. Forbes. https://www.forbes.com/sites/sethjoseph/2026/01/12/why-pharmacies-like-walgreens-rite-aid-and-independents-are-dying/
22. Fein, A J. Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook. 2025. Drug Channels. https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html
23. Fein A. Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook. 2025. Drug Channels. https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html
24. Fein A. The Top Pharmacy Benefit Managers of 2023: Market Share and Trends for the Biggest Companies—And What's Ahead. 2024. Drug Channels. https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html

[25] Xu J, Trish E, Joyce G. Pharmacy switching in response to preferred pharmacy networks in Medicare Part D. Health Serv Res. 2022;57(5):1112-1120. doi:10.1111/1475-6773.13973

[26] What is Telepharmacy? 2017. Pipeline Rx. https://www.pipelinerx.com/article/what-is-telepharmacy/

[27] Advantages and Disadvantages of Telepharmacy Services: Know What to Look For. 2025. CPS Solutions. https://perspectives.cps.com/advantages-and-disadvantages-of-telepharmacy-services-know-what-to-look-for

[28] Iftinan GN, Elamin KM, Rahayu SA, Lestari K, Wathoni N. Application, Benefits, and Limitations of Telepharmacy for Patients with Diabetes in the Outpatient Setting. J Multidiscip Healthc. 2023;16:451-459. Published 2023 Feb 19. doi:10.2147/JMDH.S400734

[29] Dowell M A. The Evolving Telepharmacy Dispensing Landscape. *US Pharm*. 2025;50(10):31-36. https://www.uspharmacist.com/article/the-evolving-telepharmacy-dispensing-landscape

[30] Fountain S. Advocate Health Care launches prescription vending machines to address pharmacy desert. 2025. Chicago Crusader. https://chicagocrusader.com/advocate-health-care-launches-prescription-vending-machines-to-address-pharmacy-desert/

[31] Cunningham, M. Amazon to start offering prescription drugs through vending machines. 2025. CBS News. https://www.cbsnews.com/news/amazon-launch-prescription-drug-pharmacy-kiosks-one-medical/

[32] Terrie Y C. Pros and Cons of Mail-Order Pharmacy Services: Views from Clinicians, Patients. 2022. Pharmacy learning Network. https://www.hmpgloballearningnetwork.com/site/pln/commentary/pros-and-cons-mail-order-pharmacy-services-views-clinicians-patients

[33] Broadband. US Department of Agriculture. 2025. https://www.usda.gov/sustainability/infrastructure/broadband

[34] Li Y, Spoer BR, Lampe TM, et al. Racial/ethnic and income disparities in neighborhood-level broadband access in 905 US cities, 2017-2021. Public Health. 2023;217:205-211. doi:10.1016/j.puhe.2023.02.001

[35] Pharmacists. 2025. American Medical Association. https://www.ama-assn.org/topics/pharmacists

[36] Pros and Cons of Telepharmacy–Plus, Our Top 4 Telemedicine Sites. 2023. PBA Health. https://www.pbahealth.com/elements/pros-and-cons-of-telepharmacy-plus-our-top-4-telemedicine-sites/

[37] Pharmacist and Pharmacy Organizations Commend 2026 Spending Bill with Important PBM Provisions, Urge Passage. 2026. National Association of Chain Drug Stores. https://www.nacds.org/pharmacist-and-pharmacy-organizations-commend-2026-spending-bill-with-important-pbm-provisions-urge-passage/

[38] US Department of Labor proposes historic pharmacy benefit manager fee disclosure rule. 2026. US Department of Labor. https://www.dol.gov/newsroom/releases/ebsa/ebsa20260129

[39] Schladen M. Ohio Medicaid got rid of big middlemen, paid pharmacies more and saved $140 million, report says. 2025. Ohio Capital Journal. https://ohiocapitaljournal.com/2025/04/17/ohio-medicaid-got-rid-of-big-middlemen-says-it-paid-pharmacies-a-lot-more-and-saved-140m/

[40] About the SPBM and PPAC. 2022. Ohio Department of Medicaid: Next Generation Program. https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager

[41] SPBM Program Review/Experience Analysis. 2025. Ohio Department of Medicaid: Next Generation Program. https://acrobat.adobe.com/id/urn:aaid:sc:us:9e7a9930-022d-42a0-b3c5-73a702cc00c5

[42] Rowland D. Case study of attempts at drug-pricing reforms in Ohio shows promise and peril for the Trump administration and Congress. 2025. Health Care Un-Covered. https://healthcareuncovered.substack.com/p/case-study-of-attempts-at-drug-pricing

[43] New Free Program Launches to Address Rural Pharmacy Shortage, Equip Next Generation of Pharmacy Owners. 2025. National Community Pharmacists Association. https://ncpa.org/newsroom/news-releases/2025/10/20/new-free-program-launches-address-rural-pharmacy-shortage-equip

[44] Incentive Grants. 2025. American Pharmacists Association Foundation. https://www.aphafoundation.org/incentive-grants

[45] Expanding Pharmacy Access, Strengthening Independent Pharmacies. 2025. LucyRx. https://lucyrx.com/sparc/

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

Mail Service Pharmacy H-120.989

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

Improve Safety of Mail-Ordered Medication H-120.936

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

National Mail Order Pharmacy Practices H-120.962

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

Mail Order Pharmacies and Interface with Current Pharmacy Hubs H-120.940

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

Internet Prescribing H-120.956

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

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "claw backs"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. (CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19)

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

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

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

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

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924
Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies,
and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice. (BOT Rep. 17, A-18; Reaffirmed: 235, I-18)

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

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

Opposing Pharmacy Benefit Manager Spread Pricing H-110.957

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

AMA Response to Pharmacy Intrusion Into Medical Practice H-35.961

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

Health Insurance Company Purchase by Pharmacy Chains D-160.920

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

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

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

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-26

Subject: Inclusion of Discounted Prescription Medication in Patient Cost-Sharing

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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

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

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

BACKGROUND

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

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

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

PATIENT ASSISTANCE PROGRAMS

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

For individuals who are beneficiaries of government funded insurance plans, there are PAPs offered by state and federal governments when medications are prohibitively expensive. For example, Medicare beneficiaries who meet certain annual income and resource limits qualify for the "Extra Help" or Low-Income Subsidy which limits OOP payments beyond the larger Medicare limits.[16] To qualify for this program, individuals must be dual-eligible and enrolled in a Medicaid drug coverage plan, make less than $2,015 per month, and have total assets below $18,090. Individuals who are also enrolled in Medicaid, Supplemental Security Income, or a Medicare Savings Program automatically qualify. For these beneficiaries, all generic drugs have an associated copay of just over $5 and all name-brand drugs have a copay of just under $13. If beneficiaries also qualify for Medicaid, these copays can be as low as $1.60 for generics and $4.90 for name-brand drugs.[17] In addition to federal programs, nearly every state has a program designed to cover the cost of prescriptions not covered by Medicare Part D plans. In addition, most states have State Pharmaceutical Assistance Programs (SPAPs). These programs are designed to reduce the cost of medication related spending for targeted populations, often those who have an income

under a set level, are under/uninsured, have a specific diagnosis, and/or those over 65 years of age.[18] For example many, but not all, states have a specific program designed to ensure that individuals with HIV/AIDS are able to access the necessary medications. Additional SPAPs are designed to center around seniors who are unable to access medications, while others are more general and apply to broader populations. For example, Alabama has one SPAP designed to assist in accessing HIV/AIDs medications (Alabama AIDS Drugs Assistance Program) and another designed to support seniors (SenioRx) who cannot afford their medications.[18]

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

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

In addition to both government and non-governmental assistance programs, coupon or discount cards have grown in accessibility and popularity across the country. These cards are primarily based on three types of discounts: manufacturer, pharmacy-specific, and prescription coupon. Manufacturer discount cards are submitted by the patient to the pharmacy and the manufacturer then pays the difference between the patient payment and actual cost. For example, if a patient paid $50 when using the discount card on a medication that typically costs $100 OOP, the manufacturer would reimburse the pharmacy the remaining $50.[26] Pharmacy-specific discount cards are unique to a pharmacy and generally allow patients to pay a

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

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

LEGISLATION AND REGULATION

To address the issues raised by copay accumulator programs, some states have implemented legislation and/or regulation to require health plans to include reductions in OOP expenses for prescription drugs in cost-sharing calculations.[30] States vary in their requirements but generally necessitate that insurance plans include a combination of third-party payments, financial assistance, discounts, and/or product vouchers in cost-sharing totals. However, many states have faced challenges in implementing these laws due to conflicts with HDHP requirements and health savings account (HSA) eligibility. Specifically, there is concern that the credit for financial assistance, prior to meeting a deductible, could cause a beneficiary to be ineligible to contribute to their HSA. In other words, to maintain HSA eligibility, beneficiaries must

meet a statutory deductible before discounts or coupons can be applied to cost-sharing calculations.[30,31] States have generally managed to work around this requirement by broadening legislation language or allowing for exceptions to ensure that those with HDHP/HSA plans are not ruled ineligible.[30]

As of the writing of this report, 25 states, the District of Columbia, and Puerto Rico have laws aimed at addressing copay accumulator adjustments by insurers and PBMs. While states vary in the specifics of their legislation, many focus on a basic requirement for all payments to be included in copay calculations. In most states, the requirements apply to all state regulated plans, meaning that some plans may be exempt. For example, Illinois, via the Managed Care Reform and Patient Rights Act, requires that any state regulated health plan must count third party payments, financial assistance, discounts, product vouchers, or any other reduction in OOP expenses on prescription drugs toward cost-sharing totals.[32] Kentucky law prohibits state regulated payers and PBMs from excluding payments via coupons, discounts, or vouchers when calculating cost-sharing. The law does allow for the use of copay accumulators when a generic alternative is available with an exception if the prescriber deems the brand-name drug is medically necessary or approved by insurance.[33,34] Texas requires that health plans and PBMs apply any third-party payment, financial assistance, discount, product voucher, or other reduction in OOP expenses be included in calculations for deductibles, copays, cost-sharing responsibility, or OOP maximum. Further, Texas law shares the Kentucky exemption when a name-brand drug is medically necessary or approved by insurance.[34]

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

AMA POLICY AND ADVOCACY

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

In addition to policies oriented towards cost-sharing/copays and OOP spending, the AMA has extensive policy designed to improve the affordability of prescription drugs. Policies H-110.980 and H-110.987 demonstrate efforts to ensure that patients have access to affordable medications. These policies discuss AMA standards for drug affordability, process transparency, and patient access. Policy

H-110.986 discusses AMA support for adding value metrics into drug prices. In conjunction with the aforementioned policies that address all payer types, Policy D-330.954 specifically focuses on managing prescription drug prices in Medicare and outlines support for price negotiation. Along with aforementioned D-110.986, Policies D-120.988 and D-120.934 target PBMs and the need for increased regulation and transparency. Specifically, Policy D-120.934 outlines AMA steps to ensure that PBMs do not prevent physicians from appropriately treating patients and Policy D-120.988 details prevention of appropriate treatment by PBMs. Combined with its grassroots advocacy campaign TruthinRx, the AMA has sent a significant number of letters to legislators, regulators, and payers working to regulate PBMs and make prescription drugs affordable. Finally, the AMA voiced support for the PBM regulations passed in the Consolidated Appropriations Act of 2026.

DISCUSSION

Patient OOP spending is typically utilized to calculate cost-sharing amounts. For example, patients will usually need to spend a certain amount OOP to achieve their deductible amount. Once met, the payer will pay a larger share of the accrued health care costs. While this generally remains the same with prescription drug spending, the introduction of PAPs has complicated the process. PAPs can take a wide variety of forms and may be sponsored by governmental and non-governmental organizations. Due to the high, and rising costs of prescription drugs in the United States, patients continue to search for methods to make their medications more affordable. For those who qualify, government and private programs can help to reduce costs. For others, drug manufacturer discounts and support programs can assist in affordability. However, these programs often have specific eligibility qualifications that many do not meet, and as a result many have begun to utilize coupons/discount cards.

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

RECOMMENDATION

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

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

Fiscal Note: Minimal

REFERENCES

1. Cost Sharing. 2025. CMS https://www.healthcare.gov/glossary/cost-sharing/
2. Deductible. 2025. CMS https://www.healthcare.gov/glossary/deductible/
3. Out-of-Pocket Maximum. 2025. CMS https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/
4. US Supreme Court Preserves ACA's No-Cost Preventive Care – At least for now. 2025. California Medical Association. https://www.cmadocs.org/newsroom/news/view/ArticleId/50932/U-S-Supreme-Court-preserves-ACA-s-no-cost-preventive-care-at-least-for-now
5. Co-payment. 2025. CMS https://www.healthcare.gov/glossary/co-payment/
6. Deductibles in ACA Marketplace Plans, 2014-2026. 2025. KFF. https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/
7. How ACA Marketplace costs compare to ESI. 2025. KFF. https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/
8. Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage. 2024. KFF. https://www.kff.org/private-insurance/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
9. H.R.5376 - An act to provide for reconciliation pursuant to title II of S. Con. Res. 14. "The Inflation Reduction Act of 2022. https://www.congress.gov/bill/117th-congress/house-bill/5376/text
10. Medicare Cost-Sharing Rates. 2025. Center for Medicare Advocacy. https://medicareadvocacy.org/medicare-cost-sharing-rates-premiums-deductibles/
11. Cubanski J, Damico A. Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2025. 2025. KFF. https://www.kff.org/medicare/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2025/#:~:text=Whereas%20most%20MA%2DPD%20enrollees,drugs%20covered%20under%20Part%20D.
12. Cost Sharing Out of Pocket Costs. Medicaid.gov. 2025. https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs
13. Pollitz K, Pestaina K, Montero A, Lopes L, Valdes I, Kirzinger A, Brodie M. KFF Survey of Consumer Experiences with Health Insurance. 2023. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
14. Long M, Salaga M, Pestaina K. Copay Adjustment Programs: What are They and What do They Mean for Consumers. 2024. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
15. Amil-Rosario A, Slejko J, dosReis S. Changes in cost-related nonadherence among US adults with multiple chronic conditions from 2019 to 2023. 2025; Journal of Man Care & Spec Pharm. 31(7). https://www.jmcp.org/doi/10.18553/jmcp.2025.31.7.662
16. Prescription Drug Assistance Programs. CMS. 2025. https://www.cms.gov/medicare/coordination-benefits-recovery/prescription-drug-assistance-programs
17. Extra Help Basics. 2026. Medicare Rights Center: Medicare Interactive. https://www.medicareinteractive.org/understanding-medicare/cost-saving-programs/the-extra-help-low-income-subsidy-lis-program/extra-help-basics#:~:text=Key%20Takeaways,a%20Medicare%20Savings%20Program%20(MSP)
18. State Pharmaceutical Assistance Programs. 2022. National Conference of State Legislators. https://www.ncsl.org/health/state-pharmaceutical-assistance-programs#:~:text=Summary%20State%20Pharmaceutical%20Assistance%20Programs,support%20from%20the%20federal%20government
19. Who we are. 2026. ArrayRx. https://www.arrayrxsolutions.com/Our-story
20. Wilkerson J, Parker JE, Cirruzzo C, Chen E, Payne D. TrumpRx claims to offer the lowest prices. But many drugs have cheaper generics. 2026. STAT. https://www.statnews.com/2026/02/06/trumprx-discount-drug-website-undercut-by-cheaper-generics/
21. Choi J. How much will TrumpRx really cut down your drug costs?. 2026. The Hill. https://thehill.com/policy/healthcare/5727385-trumprx-drug-prices-how-much-savings/
22. Fact Sheet: 10 Reasons Why TrumpRx is an Utter Joke. 2026. Protect Our Care. https://www.protectourcare.org/fact-sheet-10-reasons-why-trumprx-is-an-utter-joke/
23. Chase L. What Are Patient Assistance Programs? 2022. Good Rx. https://www.goodrx.com/healthcare-access/patient-advocacy/what-are-patient-assistance-programs?srsltid=AfmBOooOKIaUEmZJvT4TrTKs6wz8AIuZ8oyUwwIrJCI32x0wk57uQwaI

[24.] Murphy M, Rodis J. Prescription discount cards: Who do they benefit? Who do they hurt? Ohio State University College of Pharmacy. 2025. https://pharmacy.osu.edu/news/prescription-discount-cards-who-do-they-benefit-who-do-they-hurt
[25.] Disease Fund. PAN Foundation. https://www.panfoundation.org/find-disease-fund/
[26.] Hilas O. A Pharmacist's Primer on Prescription Discount Cards. *US Pharm.* 2021;46(10):21-23. https://www.uspharmacist.com/article/a-pharmacists-primer-on-prescription-discount-cards
[27.] Ryan E, Fitts E. The Hidden Costs of Discount Cards: Understanding Copay Accumulator Adjustment. 2020. DiaTribe Learn. https://diatribe.org/diabetes-medications/hidden-costs-discount-cards-understanding-copay-accumulator-adjustment
[28.] Long M, Salaga M, Pestaina K. Copay Adjustment Programs: What Are They and What Do They Mean for Consumers? 2024. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
[29.] Issue Brief: Alternative Funding Programs. AMA. 2025. https://www.ama-assn.org/system/files/issue-brief-alternative-funding-programs.pdf
[30.] Legal Alert: Drug Discount Programs in Conflict with Federal Regulations. 2021. Alera Group. https://aleragroup.com/news/legal-alert-drug-discount-programs-conflict-federal-regulations
[31.] HHS Drops Appeal in Drug Coupon Case. 2024. Groom Law Group. https://www.groom.com/resources/hhs-drops-appeal-in-drug-coupon-case/
[32.] Illinois Public Act 101-0452. https://www.ilga.gov/documents/legislation/publicacts/101/101-0452.htm
[33.] Kentucky Governor Beshear Signs New Copay Accumulator Law. 2021. Aimed Alliance. https://aimedalliance.org/kentucky-governor-beshear-signs-new-copay-accumulator-law/
[34.] Texas HB 999-88th Legislative Session. 2023. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB999
[35.] US District Court. HIV and Hepatitis Policy Institute et al., v. United States Department of Health and Human Services et al. 2023. https://bit.ly/48zbAJN
[36.] Copayment Adjustment Programs. 2025. National Center for State Legislators. https://www.ncsl.org/health/copayment-adjustment-programs/maptype/tile#toggleContent-12877

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

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

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

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

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

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.

   g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
   h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
   i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
   a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
   b. The use of any international drug price index or average should preserve patient access to necessary medications.
   c. The use of any international drug price index or average should limit burdens on physician practices.
   d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;

b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

Incorporating Value into Pharmaceutical Pricing H-110.986

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

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

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

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

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934
1. Our American Medical Association will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Rural Health Transformation Program Update & Workforce Challenges

EXECUTIVE SUMMARY

As a follow-up to CMS Report 3-I-25, Payment Models to Sustain Rural Hospitals, the Council initiated this report to provide an update on the Rural Health Transformation (RHT) program and discuss workforce challenges faced by physicians in rural settings.

In an attempt to address funding concerns in rural settings resulting from the disproportional impact of cuts to Medicare, Medicaid, and the Affordable Care Act in H.R. 1, a one-time $50 billion RHT program was created. Three-quarters of funding will be distributed across five years, based on state applications, Centers for Medicare & Medicaid Services (CMS)-evaluated state need, and CMS-scoring of state initiatives and policies. The other one-quarter of funding will be distributed based on state policy and application alignment with the administration's stated goals and agenda. While the RHT program is a significant investment in rural health, it remains to be seen if the program is able to not only make up for deficits but support improvements for rural Americans. In addition to reviewing information on the RHT program, the Council reviewed information related to workforce challenges that are faced by rural physicians. Rural communities face significant challenges in both attracting and retaining physicians. Issues such as a lack of infrastructure, complicated certification/training opportunities, and physician burnout significantly increase the challenges faced in rural communities. Further, international medical graduates and rural-born or rural-trained medical students have been shown to be more likely to practice in rural settings, and thus programs to support and incentivize these physicians towards rural settings could bolster the rural physician workforce.

Based on its review of the RHT program and rural workforce issues, the Council recommends the adoption of four new policies. First, policy to closely monitor and educate physicians and legislators regarding the RHT program and similar initiatives. Second, policy to support the development and funding of programs designed to both implement and expand telehealth in rural settings. Third, policy to support efforts to ensure that physicians practicing in rural settings have access to continuing medical education and professional development requirements. Fourth, policy to support the expansion of programs designed to support or define physician shortage areas to include specialties necessary for the functioning of a rural medical practice or hospital. Finally, the Council recommends the reaffirmations of Policy H-465.994, which outlines efforts to support rural health solutions, Policy D-200.980, which details strategies to bolster the physician workforce in underserved areas, and Policy H-465.988, which focuses on supporting the physician workforce through education and practice-based solutions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-26

Subject: Rural Health Transformation Program Update & Workforce Challenges

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

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

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

BACKGROUND

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

In rural settings, hospitals and medical practices face a unique challenge in that payments often do not cover the actual cost of care. Some federal programs do bolster Medicare payment rates to offset a portion of the discrepancy. However, these programs are primarily focused on hospitals that meet specific criteria, meaning that physician practices and non-designated hospitals are not eligible to receive these additional funds.[3] Moreover, even for those hospitals that are able to receive special designation, the increased Medicare payment rates are often not enough to cover the deficits from other payers.[3] Medicare Advantage (MA) plans have proven to be particularly

problematic for those practicing in rural settings as protections found in traditional Medicare do not carry over to MA plans and issues with payment can be even worse than with other payers.[4,5] Importantly, Medicaid also makes up a relatively significant portion of the rural payer mix, with 41 states adopting some kind of Medicaid expansion program, decreasing the number of uninsured rural patients. To assist in mitigating the cost discrepancies, Medicaid provides supplemental payments to match Medicare payment rates.[6] However, this is not available in all practice settings nor enough to cover all deficits.[6] Additionally, these deficits are often exacerbated by uninsured or underinsured patients. More detailed information on rural payment and payer mix can be found in CMS Report 6-I-23 and CMS Report 3-I-25.

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

Experts anticipate that over 10 million Americans will lose health insurance coverage as a result of the changes in H.R. 1 and that, across payer type, beneficiaries will face significant increases in premium costs.[8,9] It is projected that in a majority of states, this premium increase will be more significant for rural Americans. Specifically, analyses have shown that on top of the 18 percent increase for all private health plans, rural Americans will face a 107 percent premium increase compared to the 89 percent premium increase for urban residents.[8,9] Additionally, rural residents who utilize the ACA Health Insurance Marketplace Exchange ("Marketplace") to secure insurance coverage are anticipated to experience premium increases that are 28 percent higher than urban residents, primarily driven by the lack of extension of previously available tax credits designed to help make coverage affordable.[8,9] This is problematic as rural communities rely more heavily on affordable Marketplace plans to obtain health insurance.[8,9] Further, due to additional challenges around rural employment and coverage determination logistics in rural settings, it is anticipated that the Medicaid work requirements outlined in H.R. 1 will disproportionately impact rural communities.[9,10] According to the Centers for Medicare & Medicaid Services (CMS), there have not been actual cuts to Medicaid or other public coverage options, but rather that these expenditures were "slowed" and that any reduction in funding is focused on reductions of waste and/or fraud. However, rural health leaders and researchers have explained that these policy changes have already resulted in funding reductions negatively impacting rural health facilities and will likely continue to disproportionately impact rural providers and the communities they serve.[11] Experts, providers, and patients have voiced significant concern that these coverage losses have the potential to significantly worsen the landscape of rural health through increased financial stress on vulnerable rural hospitals and practices.

RURAL HEALTH TRANSFORMATION (RHT) PROGRAM UPDATE

In an attempt to address concerns around funding reductions, H.R. 1 included a one-time $50 billion program designated for rural health transformation.[10,12] While the RHT program is clearly a significant investment in rural health, it is anticipated that it will not make up for the projected

losses to rural hospitals and providers as a result of policy changes due to H.R. 1. It is projected that changes made to the ACA, Medicare, and Medicaid will result in rural hospitals loosing $137 billion over the next 10 years, meaning that even with the rural health fund, rural hospitals are anticipated to lose $87 billion over the next decade due to patients who will lose coverage through Medicare, Medicaid, and/or Marketplace plan changes.[10,12,13] The deficit created by the cuts resulting from the passage of H.R. 1, and other policy decisions such as the expiration of the enhanced ACA tax credits, is likely to cause financial problems for rural hospitals and other health care providers beyond what is potentially solved by the dollars dispersed through the RHT program.[10,13]

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

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

In addition to potential significant funding discrepancies between states, the ambiguity of the fund allocation may mean that rural health care providers may not receive the full allocated funds.[10,12,13,14] For example, states are given the ability to direct funding towards urban and suburban settings with the approval of CMS.[10,12,13,14] Further, the administration has outlined intentions to "claw back" funding dispersed via the RHT program should states not successfully implement the intended program(s) in the allotted timeline. The program grants state a limited timeline, at most five years, to implement the initiatives outlined in applications. States and national rural health advocacy organizations have voiced significant concerns that this timeline is not reasonable and, as a result, funding that is given to many states may end up being taken back by the federal government.[17] Not only do states have a limited timeline to implement these policies, the program's notice of funding outlined a potential risk to state funding beyond the first year if states do not demonstrate outcomes deemed sufficient by CMS. For many states this means that new policies will need to be implemented that align with stated MAHA/administration goals and should these policies not be implemented, funding beyond the first year may be limited or reduced. Further, the funding from this program is limited to the next five years, but the reductions in Medicare, Medicaid, and ACA funding or coverage are ongoing. As a result, after the RHT program is finished, the impacts of the cuts are likely to remain and rural health providers/facilities will be without additional support to mitigate the cuts.[18] While the RHT program will likely help mitigate some of the funding reductions faced in rural settings, the level of compensation may be inadequate and the potential for politicization of available funds may result in many rural residents loosing access to crucial health care.

RURAL WORKFORCE CHALLENGES

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

Infrastructure

Beyond hospital closures, the chronic lack of investment in rural infrastructure has resulted in many rural communities lacking basic infrastructure necessary to support community growth or maintain an adequate physician workforce. These communities often lack resources such as updated roads, utilities, broadband access, schools, and sanitation necessary to attract and retain businesses and bolster economies.[27] As infrastructure becomes less maintained, businesses close or

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

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

Physician Recruitment and Retention

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

While states vary widely in proportions of practicing IMGs, likely due to differing visa legislation and regulation, nationwide estimates continually demonstrate that IMGs are vital to ensuring that rural Americans have access to physicians.[38] This became a greater challenge for many hiring facilities with the implementation of a new H-1B visa fee and changes to the visa lottery process. Historically, the visa lottery process was randomized, but the Department of Homeland Security (DHS) recently implemented a weighting system based on higher skill and pay positions. Further, a $100,000 fee is now attached to all H-1B petitions, which for many rural facilities is an insurmountable and/or unsustainable figure. A number of health care advocacy organizations, including the AMA, have urged DHS and the Trump administration to implement a fee exemption for health care professionals. In March 2026, a bipartisan bill (H.R. 7961; H-1Bs for Physicians and the Healthcare Workforce Act) was introduced and if passed would exempt physicians and

health care professionals from the aforementioned $100,000 filing fee attached to new H-1B petitions. However, at the time that this report was written, this legislation has not passed Congress and no such exception has been put in place.[38,39]

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

POTENTIAL SOLUTIONS

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

Experts agree that in addition to encouraging rural-born medical students to return to rural practice as physicians, it is equally important to expose non-rural-born medical students to these communities. For example, the University of Washington School of Medicine's Rural Underserved Opportunities Program allows medical students to rotate through rural care settings in five states during their first two years of medical education. This program has shown that their students who train in rural sites are twice as likely to return to practice as physicians in rural areas.[45] Other programs, such as the Family Medicine Rural Residency Program, can be found across the country and are designed to expose physicians to a variety of rural practice settings during their residency. Specifically, this program includes both inpatient and outpatient rotations at a hospital which is the only one in the county.[46] These programs, sometimes referred to as "Grow Your Own Doctor" programs, can be instrumental in ensuring that medical students and residents are more likely to return to rural medical practice for their career.

Further, loan forgiveness programs continue to provide an incentive for physicians to practice in rural communities.[43,47] The Health Resources and Services Administration (HRSA) offers a number

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

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

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

To further support and attract rural-practicing physicians the federal government created the Health Professional Shortage Area (HPSA) designation and assigned particular benefits. While HPSAs are not exclusive to rural settings, there is frequent overlap. HPSAs are a geographic, population, and/or facility that has a shortage of primary, dental, or mental health care providers.[57] Geographic HPSAs, most common for rural settings, are areas where the entire population is experiencing a shortage of providers. Population HPSAs are defined as a shortage of providers for a specific population in a geographic area. For example, unhoused or migrant farm workers in a set area.

Facility defined HPSAs include set facilities that serve a population or geographic area facing a provider shortage.[57] While not an exhaustive list, Federally Qualified Health Centers, Indian Health Facilities/Hospitals, and Rural Health Clinics often meet the criteria to be defined as a facility HPSA. Currently, there are just under 8,500 primary care HPSA designations across type, which is inclusive of over 92 million people.[58] Physicians practicing in HPSAs are able to access a number of incentives, the most significant of these incentives are related to scholarships/loans, immigration, and payment bonuses. Specifically, physicians are able to access NHSC scholarships and loan repayment, the J-1 visa waiver program which expedites the immigration process, and, assuming the physician serves Medicare beneficiaries, a quarterly Medicare bonus payment. While research has not demonstrated an improvement in physician workforce across all types of HPSAs, it has shown that this designation seems to make significant improvements in rural settings, demonstrating more favorable patient-physician ratios.[58,59] Specifically, after a HPSA designation significant increases in primary care physicians were shown resulting in, rural HPSAs having an average of 5.4 more primary care physicians than non-HPSA rural settings.[59] While primary care is essential to overall health, it is also important that rural communities have access to specialty physicians when the need arises. Further, for a rural hospital to remain fully functional, there must be an ability to attract and retain physicians beyond primary care. The success of the HPSA designation in rural primary care could indicate that an expansion to other specialties may similarly bolster the rural physician workforce. While none of these solutions alone will solve the health care problems faced by rural communities, the solutions mentioned above have been shown to have an impact and are specific, practical, and realistically achievable.

AMA POLICY AND ADVOCACY

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

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

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

DISCUSSION

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

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

Internationally trained physicians could also serve to improve rural health workforces, yet the solution faces barriers to success. Although IMG physicians have been shown to be more likely to practice in rural settings, the complicated immigration and certification process in the U.S. can introduce barriers to this solution. Another promising potential solution is educational pathways that promote rural health practice. Through medical school and residency experiences in rural communities, physicians are introduced to the benefits of practice in these settings and are more

likely to return. Similarly, programs that help to pay off or forgive student loans have shown to be successful in attracting and retaining talent. In order to both support IMG's ability to practice in the rural United States and to promote U.S.-trained physicians in rural practice, the Council recommends the reaffirmation of Policy D-200.980 which outlines support for scholarship, loan repayment or forgiveness programs, and the expansion of visas for IMGs. Specifically, this policy supports collaborative efforts to secure funding and advocate for the retention and expansion of relevant programs such as the NHSCs and the Conrad 30 visa. Further, the Council recommends the reaffirmation of Policy H-465.988 which outlines educational strategies to attract and retain physicians to rural settings. This policy details efforts to ensure that appropriate training slots are available for medical students and residents, that education is delivered in a manner that is accessible, and that funding is maintained or expanded to secure these program efforts.

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

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) monitor legislative and regulatory proposals related to the rural health transformation program or similar rural health initiatives to educate physicians and policymakers regarding the potential opportunities and challenges associated with such programs. (New HOD Policy)

2. That our AMA support the development of funding avenues designated to support costs associated with telehealth in rural hospitals and medical practices. (New HOD Policy)

3. That our AMA support the development and implementation of programs that ensure physicians practicing in rural settings have access to opportunities to meet continuing medical education and continuing professional development requirements. (New HOD Policy)

4. That our AMA encourage the expansion of programs designed to define physician shortage areas and support physicians working in these areas to include specialties necessary to the functioning of a rural medical practice or hospital. (New HOD Policy)

5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and innovate solutions to improve rural health. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-200.980, which outlines support for various strategies to bolster the physician workforce in underserved areas, including rural communities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-465.988, which specifies strategies and efforts to improve the physician workforce that focus on education and practice solutions. (Reaffirm HOD Policy)

Fiscal Note: Minimal

REFERENCES

1. Rural Health Needs in America: Challenges & Solutions. 2025. NICHM. https://nihcm.org/publications/rural-health-needs-in-america-challenges-and-solutions?utm_source=NIHCM+Foundation&utm_campaign=f7c44dbfba-2025_RuralHealthInfographic&utm_medium=email&utm_term=0_6f88de9846-f7c44dbfba-489145127
2. Orgera K, Senn S, Grover A. Rethinking Rural Health. 2023. AAMC. https://www.aamc.org/about-us/mission-areas/health-care/rethinking-rural-health
3. Sheffert E, Sandalow M. Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations. Bipartisan Policy Center. 2025. https://bipartisanpolicy.org/report/sustaining-rural-hospital-access-adjustments-to-medicare-rural-hospital-designations/
4. Freed M, Fuglesten Biniek J, Damico A, Neuman T. Medicare Advantage in 2024: Enrollment Updated and Key Trends. KFF. 2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/
5. Fugkesten Biniek J, Clerveau G, Damico A, Neuman T. Medicare Advantage Enrollment, Plan Availability and Premiums in Rural Areas. KFF. 2023. https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/
6. Medicaid and CHIP Payment and Access Commission, Medicaid and Rural Health. 2021. https://www.macpac.gov/wp-content/uploads/2020/08/MACPAC-April-2021-Meeting-Transcript.pdf
7. Uninsured Americans in Rural Communities and Medicaid. 2018. Modern Medicaid Alliance. https://modernmedicaid.org/pollingresearch/uninsured-americans-in-rural-communities-and-medicaid/
8. Lambrew J, Ford E. Rural Americans Face Unprecedented Price Hikes for Health Care. 2025. The Century Foundation. https://tcf.org/content/commentary/rural-americans-face-unprecedented-price-hikes-for-health-care/
9. National Rural Health Association. One Big Beautiful Bill and Rural Health. 2025. https://www.ruralhealth.us/getmedia/daabe69b-4fdd-4b5a-8e24-b6c22b0ebed4/OBBBA-Talking-Points-7-22-25_1.pdf
10. Miranda Ollstein A, Reader R. Trump admin doles out billions for rural health. 2025. Politico. https://www.politico.com/news/2025/12/29/trump-admin-doles-out-billions-for-rural-health-00707332
11. National Rural Health Association. One Big Beautiful Bill and Rural Health. 2025. https://www.ruralhealth.us/getmedia/daabe69b-4fdd-4b5a-8e24-b6c22b0ebed4/OBBBA-Talking-Points-7-22-25_1.pdf
12. Levinson Z, Neuman T. A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law. 2025. KFF. https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/
13. Rural Health Transformation Program: Implications and Opportunities. 2025. NRHA. https://www.ruralhealth.us/blogs/2025/10/rural-health-transformation-program-implications-and-opportunities
14. Tracking Applications for Rural Health Transformation Funds. 2025. KFF Health News. https://kffhealthnews.org/news/article/tracking-applications-for-rural-health-transformation-funds/
15. Levinson Z, Hulver S, Neuman T. State Awards From Most of the Rural Health Fund Could Vary Only Modestly Despite Large Differences in Rural Needs. 2025. https://www.kff.org/state-health-policy-data/state-awards-from-most-of-the-rural-health-funds-could-vary-only-modestly-despite-large-differences-in-rural-needs/#cf886f6c-b2af-4254-86a4-6bbc53d2ac34--h-largest-and-smallest-awards
16. O'Hagen Karl A, Young BD, Morin A. Rural Health Transformation Program: What's the Right Contracting Strategy? 2026. Manatt. https://www.manatt.com/insights/webinars/rural-health-transformation-program-what-s-the-right-contracting-strategy
17. Searing A. Unpacking the Rural Health Transformation Fund Created by Congress to Soften Impact of Medicaid Cuts on Rural Hospitals. Georgetown University McCourt School of Public Policy. 2025. https://ccf.georgetown.edu/2025/09/19/unpacking-the-rural-health-transformation-fund-created-by-congress-to-soften-impact-of-medicaid-cuts-on-rural-hospitals/
18. Rural Health Fund Will Do Little to Offset Harm to Rural Providers in Republican Megabill. 2025. Center on Budget and Policy Priorities. https://www.cbpp.org/blog/rural-health-fund-will-do-little-to-offset-harm-to-rural-providers-in-republican-megabill
19. Dall, T, et al., 2024. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Association of American Medical Colleges. https://www.aamc.org/media/75236/download?attachment
20. Scott B. 2024. Improving health in rural areas is within our collective reach. American Medical Association. https://www.ama-assn.org/about/leadership/improving-health-rural-areas-within-our-collective-reach
21. Ferguson T. CMS Rural Health Transformation Program. ICD10 Monitor. 2026. https://icd10monitor.medlearn.com/cms-rural-health-transformation-program/
22. Topchik M, Brown T, Pinnette M, Balfour B, Wiesse A. Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory. CHARTIS. 2024. https://www.chartis.com/insights/unrelenting-pressure-pushes-rural-safety-net-uncharted-territory
23. Sheffert E, Sandalow M. Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations. Bipartisan Policy Center. 2025. https://bipartisanpolicy.org/report/sustaining-rural-hospital-access-adjustments-to-medicare-rural-hospital-designations/

[24.] Tribble SJ. Buy and Bust: When Private Equity Comes for Rural Hospitals. 2022. KFF Health News. https://kffhealthnews.org/news/article/private-equity-rural-hospitals-closure-missouri-noble-health/

[25.] Stopping the Loss of Rural Maternity Care. 2025. Saving Rural Hospitals. Center for Healthcare Quality and Payment Reform. https://ruralhospitals.chqpr.org/Maternity_Care.html

[26.] Zahnd WE, Hung P, Shi SK, et al. Availability of hospital-based cancer services before and after rural hospital closure, 2008-2017. J Rural Health. 2023;39(2):416-425. https://doi.org/10.1111/jrh.12716

[27.] The Silent Crisis: How America's Rural and Small-Town Communities Are Being Left Behind. 2025. Grand Bargain Project. https://www.grandbargainproject.org/posts/the-silent-crisis%3A-how-america%E2%80%99s-rural-and-small-town-communities-are-being-left-behind

[28.] Economic Impact Study. American Medical Association. 2025. https://www.ama-assn.org/about/ama-research/economic-impact-study

[29.] Mckoy J. The Loss of a Rural Hospital is Devastating for a Local Community. Boston University: School of Public Health. 2025. https://www.bu.edu/sph/news/articles/2025/the-loss-of-a-rural-hospital-is-devastating-for-a-local-community/

[30.] Abdul Baten RB, Shrestha M. Impact of Hospital Closure on Rural Communities: A Qualitative Study. Rural Health Research & Policy Centers. 2025. https://rupri.public-health.uiowa.edu/publications/policypapers/Rural%20Hospital%20Closures.pdf

[31.] Health, Work, and Care in Rural America: Distances to Travel to Hospital-Based Health Care. New America. 2022. https://d1y8sb8igg2f8e.cloudfront.net/documents/Health_Work_and_Care_in_Rural_America_2022.pdf

[32.] Nolan D. Infrastructure NMeglect and Poverty Lead to Parasites in the Mississippi Delta. The Guardian. 2025. https://www.theguardian.com/us-news/2025/jan/01/mississippi-delta-water-parasites

[33.] Mullens CL, Collins RA, Kunnath N, Probst JC, Ibrahim AM. Trends in Travel Time to Obtain Surgical Care for Rural Patients. *JAMA.* 2025;333(16):1453–1455. https://doi.org/10.1001/jama.2025.0447

[34.] Klein S, Richardson Schoenbrun P. An Enticing Offer: How Some Rural Communities Are Winning the Competition for New Clinicians. 2024. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2024/dec/how-some-rural-communities-are-winning-new-clinicians

[35.] Horstman C, Shah A. The State of Rural Primary Care in the United States. 2025. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/nov/state-rural-primary-care-united-states

[36.] Braga B, Khanna G, Turner S. Migration Policy and the Supply of Foreign Physicians: Evidence from the Conrad 30 Waiver Program. Journal of Econ Beh & Org. 226: 2024. https://doi.org/10.1016/j.jebo.2024.106682

[37.] Smith TM. IMGs Don't Just Fill Gaps. They Can Become Leaders Too. International Journal of Med Ed. 2024. https://www.ama-assn.org/education/international-medical-education/imgs-don-t-just-fill-gaps-they-can-become-leaders-too#:~:text=%E2%80%9CMany%20IMGs%20tend%20to%20work,the%20visa%2Dwaiver%20requirement.%E2%80%9D

[38.] U.S. Physician Workforce Data Dashboard. Association of American Medical Colleges. 2023. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard

[39.] George K, Kallins L. What to Know About Fast-Approaching H-1B Visa Changes. National Conference of State Legislators. 2026. https://www.ncsl.org/state-legislatures-news/details/what-to-know-about-fast-approaching-h-1b-visa-changes

[40.] U.S. Physician Workforce Data Dashboard. Association of American Medical Colleges. 2023. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard

[41.] Coates A, Zahnd W, Burgin C. Toward a Sustainable and Diversified Rural Health Workforce. 2022. National Rural Health Association. https://www.ruralhealth.us/getmedia/f7b57994-8fb2-47b0-a6e0-12ee74591314/NRHA-Toward-a-Sustainable-Rural-Health-Workforce-Policy-Brief-2022.pdf

[42.] Recruitment challenges, solutions, and outlooks for the rural doc shortage. National Rural Health Association. 2025. https://www.ruralhealth.us/blogs/2025/07/recruitment-challenges,-solutions,-and-outlooks-for-the-rural-doc-shortage

[43.] Telehealth's impact on rural hospitals: A literature review. 2025. National Rural Health Association. https://www.ruralhealth.us/blogs/2025/02/telehealth-s-impact-on-rural-hospitals-a-literature-review

[44.] Gizaw Z, Astale T, Kassie GM. What improves access to primary healthcare services in rural communities? A systematic review. *BMC Prim Care*. 2022;23(1):313. Published 2022 Dec 6. doi:10.1186/s12875-022-01919-0

[45.] Med students given a taste of rural medicine more likely to return. UW Medicine Newsroom. 2023. https://newsroom.uw.edu/blog/med-students-given-taste-rural-medicine-more-likely-return/

[46.] Moran M. Medical programs send budding doctors to rural county 'healthcare deserts'. National Association of Counties. 2023. https://www.naco.org/articles/medical-programs-send-budding-doctors-rural-county-%E2%80%98healthcare-deserts%E2%80%99

[47.] Richardson E. Rural Healthcare: Strategic Solutions for Sustainability and Growth. 2024. Coker. https://www.cokergroup.com/insights/rural-healthcare-strategic-solutions-for-sustainability-and-growth

[48.] Scholarships, Loans, and Loan Repayment for Rural Health Professions. Rural Health Information Hub. 2024. https://www.ruralhealthinfo.org/topics/scholarships-loans-loan-repayment

[49.] Podolsky A, Kini T. How Effective Are Loan Forgiveness and Service Scholarships for Recruiting Teachers? Learning Policy Institute. 2016. https://learningpolicyinstitute.org/product/how-effective-are-loan-forgiveness-and-service-scholarships-recruiting-teachers
[50.] Pathman DE, et al. Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians. 2004. https://www.jstor.org/stable/4640788
[51.] Frieden K. Is Loan Repayment an Effective Recruitment and Retention Strategy for Healthcare Professionals? Michigan Health Council. 2023. https://www.mhc.org/post/is-loan-repayment-an-effective-recruitment-and-retention-strategy-for-healthcare-professionals
[52.] Orgera K, Senn S, Grover A. Rethinking Rural Health. Academy of American Medical Colleges. 2023. https://www.aamc.org/about-us/mission-areas/clinical-care/rethinking-rural-health
[53.] Attracting health care professionals to rural communities: What works? National Rural Health Association. 2025. https://www.ruralhealth.us/blogs/2025/03/attracting-health-care-professionals-to-rural-communities
[54.] Advocacy in action: Clearing IMGs' route to practice. American Medical Association. 2025. https://www.ama-assn.org/education/international-medical-education/advocacy-action-clearing-imgs-route-practice
[55.] Falkner, H. Disappearing Doctors: The Reshaping of Rural Healthcare and Its Impact on Rural Physician Recruitment. 2025. Jackson Physician Search. https://www.jacksonphysiciansearch.com/insights/disappearing-doctors-the-reshaping-of-rural-healthcare-and-its-impact-on-rural-physician-recruitment/
[56.] Recruitment challenges, solutions, and outlooks for the rural doc shortage. National Rural Health Association. 2025. https://www.ruralhealth.us/blogs/2025/07/recruitment-challenges,-solutions,-and-outlooks-for-the-rural-doc-shortage
[57.] What is a Shortage Designation? 2026. Health Resources and Services Administration: Health Workforce. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#:~:text=What%20is%20a%20facility%20HPSA,a%20governing%20board%20of%20directors
[58.] Primary Care Health Professional Shortage Areas. 2025. KFF. https://www.kff.org/other-health/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[59.] Goopta A, Melanson T, Susana-Castillo S. AIR Opportunity Fund: Impact of Primary Care Health Professional Shortage Area Designation on Provider Supply. 2023. American Institutes for Research. https://www.air.org/project/impact-primary-care-health-professional-shortage-area-designation-provider-supply

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

Improving Rural Health H-465.994

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

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association (AMA) recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

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

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

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

Improving Rural Health H-465.994
1. Our American Medical Association:

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

Improving Healthcare of Minority Communities in Rural Areas H-350.937

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

Addressing Equity in Telehealth and Health Technology H-480.937

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
4. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
5. Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
6. Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
7. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
9. Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: Res. 213, A-23; Reaffirmation: A-23; Modified: BOT Rep. 06, I-24)

Closing of Residency Programs H-310.943

1. Our American Medical Association:
    a. encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.
    b. reminds all institutions involved in educating residents of their contractual responsibilities to the resident.
    c. encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.

   d. will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.
   e. urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.
   f. opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.
   g. will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
   a. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
   b. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
   c. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
   d. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
   a. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
   b. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

c. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22)

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

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

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

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

Diversity in the Physician Workforce and Access to Care D-200.982
1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim

Meeting. (CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24; Reaffirmed: Res. 308, I-25)

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

Appendix A
Rural Health Transformation Program FY26 Funding

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-26)

Introduced by: Washington

Subject: Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”

Referred to: Reference Committee A

Whereas, weight bias is prevalent in health care settings, particularly for patients with obesity, and has been well-documented to be associated with an increased stress response, increased health care avoidance, and poorer health outcomes for patients[1]; and

Whereas, person-centered care is a core tenet of primary care specifically and health care generally; and

Whereas, the ICD-10 code E66.01 “morbid (severe) obesity due to excess calories” has been perceived by patients to be stigmatizing and perpetuates biased language in medicine; and

Whereas, less stigmatizing language is included in E66.811-E66.813 (obesity, class 1-3); and

Whereas, the ICD-10 code E66.01 is frequently the only code payers use for risk-adjusted payments to physicians; therefore be it

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payors for equivalent, risk-adjusted payment for alternate codes with more patient-centered, neutral, and non-stigmatizing language in place of ICD-10 code E66.01. (Directive to Take Action)

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

Received: 3/13/26

REFERENCES

1. Schwartz MW, Seeley RJ, Zeltser LM, Drewnowski A, Ravussin E, Redman LM, Leibel RL. Obesity Pathogenesis: An Endocrine Society Scientific Statement. Endocr Rev. 2017 Aug 1;38(4):267-296. doi: 10.1210/er.2017-00111. PMID: 28898979; PMCID: PMC5546881.

RELEVANT AMA POLICY

D-65.969 Use of Inclusive Language
Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will amend existing policies to ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments.

Our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, will identify other types of outdated language in AMA policies and devise a timely mechanism for editorial changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates.

D-70.942 Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
Our American Medical Association will collaborate with the Centers for Disease Control and Prevention and the National Center for Health Statistics ICD-10 Coordination and Maintenance Committee to advocate for the World Health Organization to adopt destigmatizing terminology in ICD-10 and future ICD codes and to eliminate existing stigmatizing diagnostic synonyms.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-26)

Introduced by: Pennsylvania

Subject: Study for EMTALA Relief in Psychiatric Facilities

Referred to: Reference Committee A

Whereas, Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 to ensure public access to emergency medical services regardless of a patient's ability to pay; and

Whereas, EMTALA requires hospitals to provide a medical screening examination to anyone requesting treatment for an emergency medical condition; and

Whereas, if an emergency condition is identified, the hospital must stabilize the patient before transferring or discharging them; and

Whereas, the original EMTALA bill had exempted psychiatric hospital facilities, but various exemptions were inadvertently lost in the legislative process without specific explanation; and

Whereas, EMTALA prevents hospitals from refusing treatment or transferring patients based on their insurance status or ability to pay; and

Whereas, many free-standing psychiatric hospitals are used by local law enforcement for any disruptive person in police custody, or by emergency departments that transfer intoxicated patients; and

Whereas, this unfairly burdens free-standing psychiatric facilities; therefore be it

RESOLVED, that our American Medical Association perform a study to determine whether it would be appropriate to seek EMTALA relief, exemption, or modifications for exclusively psychiatric hospital facilities. (Directive to Take Action)

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

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:103
(A-26)

Introduced by: Florida, Oklahoma, Medical Student Society

Subject: Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients

Referred to: Reference Committee A

Whereas, the United States spent an estimated $650 billion on prescription drugs in 2023 after discounts, with approximately one-third of that total—$215 billion—flowing to PBMs, wholesalers, and pharmacies rather than manufacturers, reflecting the substantial financial impact of intermediaries in the drug supply chain[1]; and

Whereas, patients frequently face high out-of-pocket costs for essential medications due to formulary exclusions, prior authorization barriers, and pricing practices driven by PBMs and insurance intermediaries, including the use of high list prices that increase patient cost-sharing even when net prices fall, a dynamic well-documented in analyses of PBM rebate structures[2,3]; and

Whereas, PBM compensation models tied to drug list prices have been shown to incentivize higher list prices and steer patients toward more expensive medications, with research indicating that delinking PBM compensation from list prices could reduce national drug spending by nearly $100 billion annually[1, 4]; and

Whereas, a growing number of Americans—including those without comprehensive insurance—use alternative platforms to obtain FDA-approved medications prescribed by licensed physicians, including coupon-based retail programs for generic and name brand drug, (e.g., GoodRx, Trump Rx), direct-to-consumer pharmacies (e.g., Mark Cuban Cost Plus Drugs), and direct manufacturer-to-patient programs (e.g., Lilly Direct, Pfizer for All), in order to reduce medication costs[5]; and

Whereas, these platforms often provide prices substantially lower than insurance-based retail prices, in part because they bypass PBM-driven markups and rebate structures, and without such platforms many patients would be unable to obtain necessary therapies[6]; and

Whereas, the American Medical Association has long-standing policies supporting access to affordable prescription drugs, reducing financial barriers for patients, and promoting transparency in pharmaceutical pricing[7]; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should match the lowest available bona fide patient price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication. (Directive to Take Action)

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

Received: 4/9/26

REFERENCES

https://schaeffer.usc.edu/research/pbm-delinking-drug-cost-savings/
https://paragoninstitute.org/private-health/pbm-101-what-they-are-and-how-they-affect-drug-prices/
AMA Policies H-110.987, H-110.980, H-125.979
AMA Policies H-125.991, H-125.984
AMA Policies H-125.991, H-125.988
AMA Policies H-110.987, H-125.979, H-125.991
AMA Policies H-110.987, H-125.979, H-125.991

RELEVANT AMA POLICY

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;

   b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
   c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

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

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
   a. The arbitration process should be overseen by objective, independent entities.
   b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
   c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
   d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
   e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
   f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
   g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
   h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
   i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
   a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
   b. The use of any international drug price index or average should preserve patient access to necessary medications.
   c. The use of any international drug price index or average should limit burdens on physician practices.
   d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

   CMS Rep. 4, I-19 Reaffirmed: CMS Rep. 3, I-20 Modified: CMS Rep. 4, A-22

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.
   Sub. Res. 724, A-14 Appended: Res. 701, A-16 Appended: Alt. Res. 806, I-17 Reaffirmed: CMS Rep. 07, A-18 Reaffirmed: BOT Rep. 20, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: CMS Rep. 2, A-21 Reaffirmed: CMS Rep. 06, A-24

Drug Formularies and Therapeutic Interchange H-125.991

It is the policy of the AMA:

(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and

(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies.
BOT Rep. 45, I-93 Reaffirmed by Sub. Res. 501, A-95 Appended: BOT Rep. 7, I-99 Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00 Reaffirmed: Res. 515, I-00 Reaffirmed: CMS Rep. 8, A-02 Reaffirmed: Res. 533, A-03 Modified: CMS Rep. 6, A-03 Modified: CSA Rep. 2, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 535, A-05 Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05 Reaffirmed: CMS Rep. 2, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmed: CMS Rep. 2, A-10 Reaffirmed: CMS Rep. 01, A-20

Generic Drugs H-125.984
Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.

(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.

(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.

(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.

(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.

(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).

(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.
CSA Rep. 6, A-02 Reaffirmed: CSAPH Rep. 2, A-07 Reaffirmation A-08 Reaffirmation A-09 Reaffirmed in lieu of Res. 525, A-10 Reaffirmed in lieu of Res. 224, I-14 Reaffirmed in lieu of: Res. 922, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-26)

Introduced by: Medical Student Section, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Improving Choice, Competition, and Affordability in the ACA Marketplaces

Referred to: Reference Committee A

Whereas, the Affordable Care Act (ACA) established state-based Health Insurance Marketplaces, providing coverage to over 21 million people through regulated exchanges with private insurers, and organizes plans into metal tiers (bronze, silver, gold, platinum) that cover varying proportions of healthcare costs (60%, 70%, 80%, and 90%, respectively)[1-2]; and

Whereas, tax credits that help pay for ACA plan premiums ("premium tax credits") are available to US citizens and lawfully present immigrants who purchase Marketplace coverage with income greater than 100% of the Federal Poverty Level, but are ineligible for public coverage (e.g. Medicaid, TRICARE, CHIP), and are not offered affordable employer-sponsored health insurance[3-5]; and

Whereas, ACA premium tax credits provide substantial savings of $5,534 per year on average to qualifying enrollees[6]; and

Whereas, premium tax credits are calculated by comparing an enrollee's income to the premium of the second-lowest cost silver plan, which acts as a "benchmark plan"; for example, if the benchmark plan has a monthly premium of $1000 but the enrollee should only be paying $250 based on their income, the enrollee provides a premium tax credit of $750 that can be applied to the premium of any plan on the Marketplace[7]; and

Whereas, increasing the benchmark plan to the second-lowest cost gold plan could increase premium tax credits and reduce out-of-pocket costs for most enrollees[8,9]; and

Whereas, the premium tax credit can only be applied to the portion of a plan's premium that covers Essential Health Benefits (EHBs), which are federally-defined health benefits that exclude essential healthcare services like dental benefits, routine eye exams, and certain forms of long-term care[10,11]; and

Whereas, when a patient's premium tax credit exceeds the premium for the selected plan, the difference is lost, leading to reduced financial support for lower-income enrollees selecting cheaper plans[10]; and

Whereas, limiting premium tax credit application to EHBs significantly limits plan choice and competition in the ACA Marketplaces, and artificially limits access to care for benefits that are not considered EHBs[12-15]; and

Whereas, addressing these inefficiencies in the ACA Marketplaces would expand competition and choice while improving affordability for patients, moving the United States closer to universal, equitable health coverage; therefore be it

RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits (New HOD Policy); and be it further

RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan. (New HOD Policy)

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

Received: 4/14/26

REFERENCES

1. Marketplace Enrollment, 2014-2024. KFF. Accessed August 25, 2024. https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/
2. Health plan categories: Bronze, Silver, Gold & Platinum. HealthCare.gov. Accessed August 25, 2024. https://www.healthcare.gov/choose-a-plan/plans-categories/
3. Who is eligible for Marketplace premium tax credits? KFF. Accessed August 25, 2024. https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/who-is-eligible-for-marketplace-premium-tax-credits/
4. Banthin J, Buettgens M, Simpson M, Levitis J. Who Benefits from Enhanced Premium Tax Credits in the Marketplace? Urban Institute. June 2024. https://www.urban.org/sites/default/files/2024-06/Who_Benefits_from_Enhanced_Premium_Tax_Credits_in_the_Marketplace.pdf
5. Lukens G. Health Insurance Costs Will Rise Steeply if Premium Tax Credit Improvements Expire. Center on Budget and Policy Priorities. June 4, 2024. https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire.
6. Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC). KFF. Accessed August 25, 2024. https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/
7. Odeyale A. Premium Tax Credit. Beyond the Basics. August 21, 2024. Accessed August 25, 2024. https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/
8. Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges | Center on Budget and Policy Priorities. April 10, 2024. Accessed August 25, 2024. https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees
9. Baumgartner JC, Gunja MZ, Collins SR. New Gold Standard: Impact Changing Coverage Standards Affordability | Commonwealth Fund. Accessed August 25, 2024. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/new-gold-standard-changing-marketplace-coverage-benchmark-affordability
10. Plan Year 2024 Qualified Health Plan Choice and Premiums in HealthCare.gov States. CMS.gov. Accessed August 25, 2024. https://www.cms.gov/files/document/2024-qhp-premiums-choice-methodology.pdf
11. APTC and CSR Basics. CMS.gov. June 2024. Accessed August 25, 2024. https://www.cms.gov/marketplace/technical-assistance-resources/aptc-csr-basics.pdf
12. Griffith K, Jones DK, Sommers BD. Diminishing Insurance Choices In The Affordable Care Act Marketplaces: A County-Base Analysis. Health Aff (Millwood). 2018;37(10):1678-1684. doi:10.1377/hlthaff.2018.0701
13. Pestaina K, Cox C, Published RW. Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers. KFF. October 30, 2023. Accessed August 25, 2024. https://www.kff.org/policy-watch/signing-up-for-marketplace-coverage-remains-a-challenge-for-many-consumers/
14. Reed NS, Altan A, Deal JA, et al. Trends in Health Care Costs and Utilization Associated With Untreated Hearing Loss Over 10 Years. JAMA Otolaryngology–Head & Neck Surgery. 2019;145(1):27-34. doi:10.1001/jamaoto.2018.2875
15. Wallace R, Long M, Published KP. Access to Adult Dental Care Gets Renewed Focus in ACA Marketplace Proposal. KFF. March 8, 2024. Accessed August 25, 2024. https://www.kff.org/policy-watch/access-to-adult-dental-care-gets-renewed-focus-in-aca-marketplace-proposal/

RELEVANT AMA POLICY

Individual Health Insurance H-165.920
Our AMA will: (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. (4) will identify any further means through which universal coverage and access can be achieved; (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. [BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by

Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-1; 2Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17]

Improving Affordability in the Health Insurance Exchanges H-165.824
1. Our American Medical Association will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (c) support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. 2. Our AMA supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (b) increasing the generosity of premium tax credits. (c) expanding eligibility for cost-sharing reductions. (d) increasing the size of cost-sharing reductions. [CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-26)

Introduced by: New York

Subject: Oppose Medicare Advantage Auto Enrollment

Referred to: Reference Committee A

Whereas, Medicare Advantage plans are promoted as providing more benefits to seniors while discounting the restrictions placed on seniors, such as narrow networks and prior authorizations; and

Whereas, seniors currently have the choice to review or change coverage annually during open enrollment; and

Whereas, there are efforts to have seniors auto enrolled in such programs, requiring them to opt out to remain in traditional Medicare actively; and

Whereas, one such plan, HR 3467, introduced by Rep. David Schweikert (R-Ariz), would automatically place seniors into the lowest premium Medicare Advantage plan in their zip code and lock them in for three years; and

Whereas, any bill that forces auto enrollment would hurt those most in need, people with cognitive impairments, low digital literacy, or limited access to trusted advisors; therefore be it

RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-26)

Introduced by: Women Physicians Section

Subject: Insurance Coverage for Scalp Cooling (Cold Capping) Therapy

Referred to: Reference Committee A

Whereas, chemotherapy-induced alopecia is one of the most distressing side effects of cancer treatment, contributing to depression, anxiety, altered body image, diminished sense of sexuality, social isolation, and reduced self-esteem, all of which significantly impair patient quality of life; and

Whereas, chemotherapy-induced alopecia can also compromise patient privacy by making a cancer diagnosis visibly apparent; and

Whereas, scalp cooling ("cold capping") is an FDA-approved therapy that significantly reduces the risk of chemotherapy-induced alopecia without compromising oncologic outcomes; and

Whereas, a meta-analysis of 501 patients demonstrated a 43% reduction in the risk of chemotherapy-induced alopecia after the use of scalp cooling; and

Whereas, a systematic review and meta-analysis of 1,959 patients receiving scalp cooling compared with 1,238 patients not receiving scalp cooling found no increase in the incidence of scalp metastases; and

Whereas, the robust body of evidence has led the National Comprehensive Cancer Network® (NCCN) to designate scalp cooling as a Category 2A recommendation, reflecting broad consensus for its use as an evidence-based intervention; and

Whereas, reimbursement for scalp cooling is inconsistent across insurance plans and geographic regions, resulting in many patients being forced to pay thousands of dollars out-of-pocket for this therapy; and

Whereas, these financial barriers affect all patients but disproportionately burden women, who are more likely to undergo chemotherapy for breast cancer and who experience greater psychosocial impact from visible hair loss due to societal expectations; and

Whereas, in 2024, New York passed Senate Bill S2063A to require private insurance companies to cover scalp cooling for chemotherapy patients; and

Whereas, in 2025, Louisiana enacted House Bill HB35 requiring coverage of integrative cancer treatments, including acupuncture, cryotherapy, and scalp cooling systems when recommended by nationally recognized cancer treatment guidelines; and

Whereas, these state-level actions demonstrate growing legislative recognition of scalp cooling as an essential component of comprehensive cancer care and establish scalable policy models

for improving equitable access to evidence-based supportive oncology interventions nationwide; and

Whereas, equitable access to supportive cancer care interventions, including scalp cooling, is integral to comprehensive cancer treatment and survivorship care; therefore be it

RESOLVED, that our American Medical Association supports insurance coverage for scalp cooling ("cold capping") for patients undergoing chemotherapy in order to minimize cost-sharing and ensure equitable access to this evidence-based intervention. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

REFERENCES

1. Kocan S, Aktug C, Gursoy A. "Who am I?" A qualitative meta-synthesis of Chemotherapy-induced alopecia and body image perception in breast cancer patients. *Support Care Cancer*. 2023;31(4):237. Published 2023 Mar 28. doi:10.1007/s00520-023-07704-8
2. Boland V, Brady AM, Drury A. The physical, psychological and social experiences of alopecia among women receiving chemotherapy: An integrative literature review. *Eur J Oncol Nurs*. 2020;49:101840. doi:10.1016/j.ejon.2020.101840
3. Contreras Molina M, Álvarez Bueno C, Cavero Redondo I, Lucerón Lucas-Torres MI, Jiménez López E, García Maestro A. Effectiveness of Scalp Cooling to Prevent Chemotherapy-Induced Alopecia in Patients Undergoing Breast Cancer Treatment: A Systematic Review and Meta-analysis. *Cancer Nurs*. 2024;47(4):319-326. doi:10.1097/NCC.0000000000001234
4. Rugo HS, Melin SA, Voigt J. Scalp cooling with adjuvant/neoadjuvant chemotherapy for breast cancer and the risk of scalp metastases: systematic review and meta-analysis. Breast Cancer Res Treat. 2017;163(2):199-205. doi:10.1007/s10549-017-4185-9
5. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Breast Cancer. Version 5.2025. Published September 2025. Accessed September 19, 2025. https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf
6. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer. Version 5.2025. Published September 2025. Accessed September 19, 2025. https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf

RELEVANT AMA POLICY

H-55.966 Cancer Survivorship Program Coverage
Our AMA recognizes cancer survivorship and cancer rehabilitation as a critical component of comprehensive cancer care and supports insurance coverage for prevention and early detection of new primary cancers and recurrences, as well as for medical care services and supportive care services, including, but not limited to, genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment, aimed at managing the long-term consequences and sequelae of cancer and its treatment.

1. Our AMA advocates for work with key stakeholders to achieve adequate coverage for cancer survivorship and cancer rehabilitation care.

[Res 119, A-25]

H-55.969 Survivorship Care Plans

1. Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients.

[Res 108, A-15; Reaffirmation: A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-26)

Introduced by: Indiana

Subject: Oversight of Medicare Advantage Plan

Referred to: Reference Committee A

Whereas, the original Medicare option established in 1965, hereafter referred to as “Traditional Medicare” (TM) decreases healthcare spending and increases access to care for seniors and persons with disabilities[1]; and

Whereas, the newer Medicare Advantage (MA) program, established in 1999, allows private health insurance companies, hereafter referred to as “MA Organizations” (MAOs), to “manage” Medicare plans[2]; and

Whereas, roughly 50% of all Medicare-eligible citizens in Indiana, ~700,000 individuals, are enrolled in a Medicare Advantage (MA) plan--an increase from 40% in 2021 and 21% in 2013[3]; and

Whereas, MA plans offer more limited healthcare provider networks compared to TM, with average coverage limited to 46% of physicians in a respective county compared to over 98% of physicians who accept TM[4]; and

Whereas, MA enrollees require prior authorization for a significantly greater number of services than those enrolled in TM, with 99% of MA enrollees requiring prior authorization for necessary services such as hospital admissions and skilled nursing facilities, which starkly contrasts with the limited services requiring prior authorization in TM[5, 6]; and

Whereas, 13% of total prior authorization denials and 18% of denied payment claims issued by MA organizations would have been approved under the coverage rules of TM[5, 7, 8]; and

Whereas, repeated claims denials by MAOs have subjected patients to delays in medical care, put community and rural hospitals at risk of closure, and led some hospitals to terminate contracts with MAOs, further compromising patients' provider networks under MA plans[9, 10]; and

Whereas, federal payments to MA plan enrollees are high and annual costs were found to be $321 higher per MA enrollee than if the same enrollee had been covered by TM[11, 12]; and

Whereas, MA insurance plans have higher rates of overhead or administrative costs (13% to 18.5%) compared to TM (2%) and have a higher overhead and profit margins than even the individual market (12.3%)[13, 14]; and

Whereas, the Medicare Payment Advisory Commission (MedPAC) estimates that the current system of benchmarks and risk-adjustments has resulted in MA enrollees costing 6% more than if they had been covered by TM, a difference that is estimated to be $27 billion in 2023 alone[16]; and

Whereas, MedPAC has recommended that the Centers for Medicare & Medicaid Services (CMS) reform the current benchmark payment system to more closely align with spending within TM[17] and changes based on MedPAC recommendations are projected to reduce total Medicare spending by an estimated $82 billion dollars by 2029[11]; and

Whereas, MAOs charge taxpayers a minimum of $88 billion per year, for supplementary benefits which often attract enrollees, however, a CBO analysis completed in 2019 found that adding dental, hearing, and vision benefits to TM and Medicaid would only cost a combined $84 billion in the most expensive year of its implementation[18]; and

Whereas, the American Medical Association (AMA) has adopted Medicare Advantage Policies D-285.959 and H-330.867 to prevent access to care limitations and improve risk-adjustment for MA enrollees[17, 18]; therefore be it

RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare (New HOD Policy); and be it further

RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions (Directive to Take Action); and be it further

RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care (New HOD Policy); and be it further

RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks (Directive to Take Action); and be it further

RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare. (New HOD Policy)

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

Received: 4/15/26

REFERENCES

1. Finkelstein A, McKnight R. *What did Medicare do? The initial impact of Medicare on mortality and out of pocket medical spending*. Journal of Public Economics. Volume 92, Issue 7. 2008. Pages 1644-1668. https://doi.org/10.1016/j.jpubeco.2007.10.005
2. Freed et al. *Medicare Advantage in 2024: Enrollment Update and Key Trends*. KFF. 8 Aug 2024. Available from: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/
3. *Medicare Monthly Enrollment*. Centers for Medicare and Medicaid Services. Aug 2024. Available from: Medicare Monthly Enrollment | CMS Data
4. Jacobson et al. *Medicare Advantage: How Robust Are Plans' Physician Networks?* KFF. 5 Oct 2017. Available from: https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/
5. Fuglesten Biniek J, Sroczynski N, Neuman T. *Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022*. KFF. 8 Aug 2024. Available from: Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022 | KFF
6. *Compare Original Medicare and Medicare Advantage*. Centers for Medicare and Medicaid Services. Available from: Compare Original Medicare & Medicare Advantage | Medicare
7. Grimm C. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. Office of the Inspector General, Department of Health and Human Services. Available from: https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/
8. Tinker M. *Examining Health Care Denials and Delays in Medicare Advantage*. Office of the Inspector General, Department of Health and Human Services. Available from: https://oig.hhs.gov/newsroom/testimony/examining-health-care-denials-and-delays-in-medicare-advantage/
9. Morgensen G. *'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, say CEOs*. Available from: https://www.nbcnews.com/news/amp/rcna121012
10. Appleby J. *Medicare Advantage increasingly popular with seniors-but not hospitals and doctors*. Fortune. 30 Nov 2023. Available from: https://fortune.com/well/2023/11/30/medicare-advantage-popular-with-seniors-not-hospitals-doctors/
11. Fuglesten Biniek J, Cubanski J, Neuman T. *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*. KFF. 17 Aug 2021 Available from: https://www.kff.org/medicare/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/
12. Moore B, Liang L. *Statistical Brief #262, Medicare Advantage Versus the Traditional Medicare Program: Costs of Inpatient Stays, 2009-2017*. Healthcare Cost and Utilization Project. 4 Aug 2020. Available from: https://www.ncbi.nlm.nih.gov/books/NBK562007/
13. *2016 Medicare Trustees Report*. Centers for Medicare and Medicaid Services. 22 June 2016. Available from: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2016.pdf
14. Ortaliza J et al. *Health Insurer Financial Performance in 2023*. KFF. 2 July 2024. Available from: https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/
15. Ramsay C et al. *Medicare Advantage: A Policy Primer 2024 Update*. The Commonwealth Fund. 31 Jan 2024. Available from: https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer
16. *Medicare Payment Policy*. Medicare Payment Advisory Committee. 15 Mar 2023. Available from: https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf
17. Chapter 1: Rebalancing Medicare Advantage benchmark policy, Report to the Congress: Medicare and the Health Care Delivery System. (2021) Available at: https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/
18. *Our Payments their Profits: Quantifying Overpayments in the Medicare Advantage Program*. Physicians for a National Health Program. Oct 2023. Available from: https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf
19. *H.R. 3, Elijah E. Cummings Lower Drug Costs Now Act*. Congressional Budget Office. 10 Dec 2019. Available from: https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf

RELEVANT AMA POLICY

Prevent Medicare Advantage Plans from Limiting Care D-285.959

1. Our American Medical Association will ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities.
2. Our AMA will advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

[Res. 706, A-21]

Medicare Advantage Plans H-330.867

1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.
2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.

[Res. 103, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-26)

Introduced by: Integrated Physician Practice Section

Subject: Ensuring Physician Input in the Development of CMMI Models

Referred to: Reference Committee A

Whereas, AMA policy is against mandatory and for voluntary CMMI models[1,2]; and

Whereas, AMA policy advocates for CMMI models that serve specialties and policies not served by current models[3]; and

Whereas, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was intended to improve the efficiency and effectiveness of healthcare using proposed solutions from frontline stakholders[4]; and

Whereas, to date, there have been no PTAC recommended models that have been tested or implemented by CMMI[5,6]; and

Whereas, CMMI has not been transparent about why PTAC recommended models are rejected for testing or implementation[7]; and

Whereas, CMMI has recently introduced a number of models including: WISeR, which for the first time placed prior authorization requirements in traditional Medicare, ACCESS, which creates a payment paradigm for digital health tools, and LEAD, which is set to succeed ACO REACH[8,9,10]; and

Whereas, “CMMI models, in aggregate, are not generating direct savings to Medicare” with some models generating substantial losses while some others do generate net savings[11]; therefore be it

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

REFERENCES

1. American Medical Association, CMMI Payment Reform Models D-385.950.
2. American Medical Association, Demonstration Project Regarding Medicare Part D H-330.894
3. American Medical Association, Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901
4. Office of the Assistant Secretary for Planning and Education, PTAC Frequently Asked Questions. https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-faqs. Accessed April 15, 2026.
5. Raths, D. (2024). Surgeon leader to Congress: Make CMMI test physician-developed APMs. *Healthcare Innovation*. April 11, 2024. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/55017602/surgeon-leader-to-congress-make-cmmi-test-physician-developed-apms. Accessed April 15, 2026.
6. Berlin, J. (2020). Going nowhere: APM committee resignations cast doubt on payment models' future. *Texas Medical Association Publications*. April, 2020. https://www.texmed.org/Template.aspx?id=53087. Accessed April 15, 2026.
7. Raths, D. (2019). PTAC members resign, frustrated with HHS rejection of payment model proposals. *Healthcare Innovation*. Nov. 20, 2019. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/21115452/ptac-members-resign-frustrated-with-hhs-rejection-of-payment-model-proposals. Accessed April 15, 2026.
8. Centers for Medicare and Medicaid Services. WISeR (Wasteful and Inappropriate Service Reduction) Model. https://www.cms.gov/priorities/innovation/innovation-models/wiser. Accessed April 15, 2026.
9. Centers for Medicare and Medicaid Services. ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model. https://www.cms.gov/priorities/innovation/innovation-models/access. Accessed April 15, 2026.
10. Centers for Medicare and Medicaid Services. LEAD (Long-term Enhanced ACO Design) Model. https://www.cms.gov/priorities/innovation/innovation-models/lead. Accessed April 15, 2026.
11. Frazier, L, Song, A. & Tripp, A. (2025). Analysis of CMMI model costs, quality performance, and transparency. Avalere Health. https://advisory.avalerehealth.com/insights/analysis-of-cmmi-model-costs-quality-performance-and-transparency. Accessed April 15, 2026.

RELEVANT AMA POLICY

CMMI Payment Reform Models D-385.950

Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties.
Citation: Res. 213, A-21

Demonstration Project Regarding Medicare Part D H-330.894

1. Our American Medical Association will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D).
2. Our AMA encourages the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs.

Citation: BOT Action in response to referred for decision Res. 142, A-07; Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and

Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.

4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy

Referred to: Reference Committee A

Whereas, patients, particularly pediatric patients, experience drug-resistant epilepsy, resulting in detrimental cognitive impairment[1,2], developmental delay[2–4], poor quality of life5, and increased mortality[6,7]; and

Whereas, patients who experience drug-resistant epilepsy and have failed all other therapies are candidates for stereotactic intracranial neuromodulation; and

Whereas, intracranial neuromodulation is a community standard for adult[8–11] and pediatric[12–15] patients with drug-resistant epilepsy that have failed other surgical interventions, including seizure focus resection, corpus callosotomy, vagal nerve stimulation, or cerebral hemispherectomy, or are deemed not to be candidates for surgical resection; and

Whereas**,** as many as 1 in 5 children suffer from chronic pain, with more girls than boys, and significant numbers of patients with refractory headache, back, and other pain[17]; and

Whereas**,** children who experience chronic pain and epilepsy are often denied insurance access to evidence-based neuromodulation therapies that are often available to adults because there are often multiple prospective and retrospective case series demonstrating the effectiveness of these treatments in pediatric patients, but a paucity of randomized studies in this population; and

Whereas, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) has published a position statement supporting the “off-label” use of neuromodulation in drug-resistant epilepsy in children[16]; therefore be it

RESOLVED, that our American Medical Association advocate for insurance coverage of intracranial neuromodulation as an acceptable treatment for appropriate pediatric patients with drug-resistant epilepsy (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for insurance coverage of chronic pain neuromodulation therapies such as intracranial, spinal cord and peripheral stimulation, as acceptable treatment for appropriate pediatric patients with chronic refractory pain. (Directive to Take Action)

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

Received: 4/15/26

REFERENCES

1. Braun, K. P. J. Preventing cognitive impairment in children with epilepsy. Curr. Opin. Neurol. 30, 140–147 (2017).
2. Freitag, H. & Tuxhorn, I. Cognitive function in preschool children after epilepsy surgery: rationale for early intervention. Epilepsia 46, 561–567 (2005).
3. Nasiri, J., Ghazzavi, M., Sedghi, M. & Pirzadeh, Z. Causes and Risk Factors of Drug-Resistant Epilepsy in Children. Iran J Child Neurol 17, 89–97 (2023).
4. Sugano, H. & Arai, H. Epilepsy surgery for pediatric epilepsy: optimal timing of surgical intervention. Neurol. Med. Chir. 55, 399–406 (2015).
5. Meador, K. J. et al. Quality of life and mood in patients with medically intractable epilepsy treated with targeted responsive neurostimulation. Epilepsy Behav. 45, 242–247 (2015).
6. Zhang, L., Hall, M. & Lam, S. K. Comparison of long-term survival with continued medical therapy, vagus nerve stimulation, and cranial epilepsy surgery in paediatric patients with drug-resistant epilepsy in the USA: an observational cohort study. Lancet Child Adolesc Health 7, 455–462 (2023).
7. Sillanpää, M. & Shinnar, S. Long-term mortality in childhood-onset epilepsy. N. Engl. J. Med. 363, 2522–2529 (2010).
8. Nair, D. R. et al. Nine-year prospective efficacy and safety of brain-responsive neurostimulation for focal epilepsy. Neurology 95, e1244–e1256 (2020).
9. Shlobin, N. A. et al. Deep Brain Stimulation of the Centromedian Nucleus of the Thalamus for Lennox-Gastaut Syndrome: A Systematic Review and Individual Patient Data Analysis. Neurosurgery 92, 703–715 (2023).
10. Hodaie, M., Wennberg, R. A., Dostrovsky, J. O. & Lozano, A. M. Chronic anterior thalamus stimulation for intractable epilepsy. Epilepsia 43, (2002).
11. Salanova, V. et al. Long-Term Efficacy and Safety of Thalamic Stimulation for Drug-Resistant Partial Epilepsy. (2015).
12. Samanta, D. et al. Advancing thalamic neuromodulation in epilepsy: Bridging adult data to pediatric care. Epilepsy Res. 205, 107407 (2024).
13. Ahn, S. et al. Bilateral centromedian nucleus of thalamus responsive neurostimulation for pediatric-onset drug-resistant epilepsy. Epilepsia (2024) doi:10.1111/epi.18031.
14. Joshi, C. N. et al. Pediatric neuromodulation for drug-resistant epilepsy: Survey of current practices, techniques, and outcomes across US epilepsy centers. Epilepsia Open 9, 785–792 (2024).
15. Khan, M., Paktiawal, J., Piper, R. J., Chari, A. & Tisdall, M. M. Intracranial neuromodulation with deep brain stimulation and responsive neurostimulation in children with drug-resistant epilepsy: a systematic review. J. Neurosurg. Pediatr. 1–10 (2021).
16. Neurosurgery Position Statement on Intracranial Neuromodulation for Drug-Resistant Epilepsy in Pediatric Patients August 2024. Congress of Neurological Surgeons (CNS) https://www.cns.org/advocacy/legislative-affairs-detail/new-powerpoint-204 (2024).
17. Chambers, Christine T.a,b,c,*; Dol, Justinea; Tutelman, Perri R.a,b; Langley, Charlotte L.a; Parker, Jennifer A.a; Cormier, Brittany T.a; Macfarlane, Gary J.d; Jones, Gareth T.d; Chapman, Darlenee; Proudfoot, Nicolea; Grant, Amyf; Marianayagam, Justinag. The prevalence of chronic pain in children and adolescents: a systematic review update and meta-analysis. PAIN 165(10):p 2215-2234, October 2024. | DOI: 10.1097/j.pain.0000000000003267

RELEVANT AMA POLICY

H-120.988 - Patient Access to Treatments Prescribed by Their Physicians

1. Our American Medical Association confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88Reaffirmed: BOT Rep. 53, A-94Reaffirmed and Modified by CSA Rep. 3, A-97Reaffirmed and Modified by Res. 528, A-99Reaffirmed: CMS Rep. 8, A-02Reaffirmed: CMS Rep. 6, A-03Modified: Res. 517, A-04Reaffirmation I-07Reaffirmed: Res. 819, I-07Reaffirmation A-09Reaffirmation I-10Modified: BOT Rep. 5, I-14Reaffirmed: Res. 505, A-15Reaffirmed: CMS Rep. 6, I-20Reaffirmed: Res. 509, I-20Reaffirmation: I-22Reaffirmed: CSAPH Rep. 01, A-23Reaffirmed: CSAPH Rep. 02, A-23Reaffirmed: CSAPH Rep. 02, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-26)

Introduced by: Senior Physicians Section

Subject: Medicaid Coverage for Incarcerated Individuals

Referred to: Reference Committee A

Whereas, medical coverage for current Medicaid patients is suspended during incarceration, even for short-term periods; and

Whereas, county jails often lack sufficient resources to provide continuity of care, including current medications for individuals with chronic medical and psychiatric conditions; and

Whereas, a significant portion of incarcerated individuals are age 65 and over, and many of these individuals suffer from chronic conditions that require continuation of long-term medications; and

Whereas, abruptly stopping or altering established medication regimens can result in serious health complications, both during incarceration and upon release; therefore be it

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration, in order to prevent adverse and potentially irreversible health outcomes resulting from the discontinuation of established and evidence-based medication therapies. (Directive to Take Action)

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

Received: 4/16/26

REFERENCES

1. Social Security Act §1905(a)(A). Webpage accessed March 17, 2026, at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
2. South AM, Fanucchi L, Lofwall M. Treating Opioid Use Disorder in Patients Who Are Incarcerated: Quandaries of a Hospitalist. *JAMA*. 2023 May 23;329(20):1738-1739.

RELEVANT AMA POLICY

H-430.986 Health Care While Incarcerated

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:
    a. linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
    d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles.
15. Our AMA advocates for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited

to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay.

16. Our AMA strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections be eligible for designation as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities.
17. Our AMA advocates for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons.
18. Our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care.

[CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23; Reaffirmed: BOT Rep.05, I-24; Appended: Res. 916, I-24; Appended: Res. 918, I-24]

D-430.990 Increased Transparency Among Psychotropic Drug Administration in Prisons

1. Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.
2. Our AMA supports increased transparency from jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

[Res. 511, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-26)

Introduced by: Illinois

Subject: Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia

Referred to: Reference Committee A

Whereas, chemotherapy-induced alopecia (CIA) is one of the most visible and distressing side effects of cancer treatment, impacting patient quality of life, body image, and mental health[1, 2]; and

Whereas, scalp cooling therapy – also known as cold cap therapy – has been shown to significantly reduce the risk of CIA among patients receiving specific chemotherapy regimens for solid tumors[3]; and

Whereas, the U.S. Food and Drug Administration (FDA) has cleared several scalp cooling systems (e.g., DigniCap and Paxman) as safe and effective medical devices to reduce hair loss in patients undergoing chemotherapy[4]; and

Whereas, studies demonstrate that patients who utilize scalp cooling report improved emotional well-being and reduced psychological distress during cancer treatment[5]; and

Whereas, access to scalp cooling therapy is currently limited by a lack of insurance coverage, leading to out-of-pocket costs ranging from $1,500 to $3,000 per treatment course, exacerbating healthcare disparities among socioeconomically disadvantaged populations[6]; and

Whereas, the state of New York passed Bill A38-A/S2063-A, signed into law on December 13, 2024, requiring insurance coverage for scalp cooling systems, thereby setting a precedent for legislative action[7,8]; and

Whereas, in the Summary of Panel Actions issued on October 18, 2024, the American Medical Association (AMA) approved three CPT® Category I codes for mechanical scalp cooling, recognizing scalp cooling as an established, medically appropriate service and reinforcing its clinical significance; the new codes will be effective January 1, 2026, and included in the CPT® 2026 code set[9]; and

Whereas, the issuance of CPT® Category I codes reflects the growing acceptance of scalp cooling therapy within standard medical practice and strengthens the justification for insurance coverage by both public and private payers[9]; therefore, be it

RESOLVED, that our American Medical Association advocate for all payers to provide insurance coverage for scalp cooling systems for patients receiving chemotherapy who are at risk of chemotherapy-induced alopecia (Directive to Take Action); and be it further

RESOLVED, that our AMA engage in continued national advocacy to promote broad and equitable access to scalp cooling therapy through public and private health insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant dermatology organizations (such as the American Academy of Dermatology), oncology organizations (such as the American Society of Clinical Oncology), and other appropriate medical societies and patient advocacy groups to advance public awareness and legislative action supporting insurance coverage for scalp cooling therapy. (Directive to Take Action)

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

Received: 4/18/26

REFERENCES

1. Trüeb RM. Chemotherapy-induced alopecia. *Semin Cutan Med Surg.* 2009;28(1):11–14.
2. Trüeb RM. Chemotherapy-induced hair loss. Skin Therapy Lett. 2010;15(7):5-7.
3. Nangia J, Wang T, Osborne C, et al. Effect of a scalp cooling device on alopecia in women undergoing chemotherapy for breast cancer: The SCALP randomized clinical trial. *JAMA*. 2017;317(6):596–605.
4. U.S. Food and Drug Administration. FDA allows marketing of cooling cap to reduce hair loss during chemotherapy. December 8, 2015 https://www.fda.gov/news-events/press-announcements/fda-clears-expanded-use-cooling-cap-reduce-hair-loss-during-chemotherapy
5. Lemieux J, Maunsell E, Provencher L. Chemotherapy-induced alopecia and effects on quality of life: A literature review. *Psychooncology*. 2008;17(4):317–328.
6. Dean JC, Salmon SE. Hair preservation with scalp cooling in patients receiving adjuvant chemotherapy for breast cancer: A review of cost-effectiveness and equity considerations. *Support Care Cancer*. 2020;28(8):3773–3778.
7. New York State Assembly. Bill A38-A/S2063-A. Passed and signed into law December 13, 2024. https://www.nysenate.gov/legislation/bills/2023/S2063/amendment/A#:~:text=2023-S2063%20-%20Summary,hair%20during%20cancer%20chemotherapy%20treatment
8. Paxman Scalp Cooling. Paxman Announces Passage of New York Law Requiring Insurance Coverage of Scalp Cooling Devices to Help Prevent Hair Loss During Cancer Treatment. December 16, 2024 https://paxmanscalpcooling.com/paxman-announces-passage-of-new-york-law-requiring-insurance-coverage-of-scalp-cooling-devices-to-help-prevent-hair-loss-during-cancer-treatment/
9. Paxman Scalp Cooling. Paxman Announces New CPT Category I Codes from the American Medical Association for Mechanical Scalp Cooling. October 19, 2024. https://paxmanscalpcooling.com/paxman-announces-new-cpt-category-i-codes-from-the-american-medical-association-for-mechanical-scalp-cooling/

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient. CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Quality Cancer Care Preservation Act H-330.897
Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs. BOT Action in response to referred for decision Res. 129, A-03; Reaffirmed: BOT Rep. 28, A-13; Reaffirmation A-15

Survivorship Care Plans H-55.969
Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients. Res. 108, A-15; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-26)

Introduced by: Illinois Delegation

Subject: Ensuring Coverage and Access to Adult Strabismus Surgery

Referred to: Reference Committee A

Whereas, adult strabismus affects approximately 1 in 25 adults (~4% prevalence), making it a common condition with significant functional consequences[1]; and

Whereas, adults with strabismus experience increased rates of falls, fractures, and musculoskeletal injuries due to impaired depth perception and binocular dysfunction, confirming strabismus as a functional and safety-relevant medical condition[2]; and

Whereas, the psychosocial and quality-of-life impact of adult strabismus is well documented, including impaired communication, reduced employability, and diminished social functioning[3], and research shows substantial improvement in daily functioning after surgical correction[4]; and

Whereas, adult strabismus surgery improves critical visual functions, including binocular summation, stereopsis, and fusion, leading to measurable improvements in functional vision and safety[5,6]; and

Whereas, the American Academy of Ophthalmology (AAO) Adult Strabismus Preferred Practice Pattern affirms that adult strabismus surgery is a medically necessary intervention for restoring binocular vision, alleviating diplopia, expanding visual fields, treating abnormal head posture, and improving psychosocial well-being[7]; and

Whereas, the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) Adult Strabismus Surgery Policy Statement 2025 reiterates that adult strabismus causes substantial functional, psychosocial, and safety burdens, and that surgery reliably improves diplopia, restores fusion, expands visual fields, and improves quality of life (AAPOS, 2025); therefore be it

RESOLVED, that our American Medical Association advocate for national insurer recognition of adult strabismus surgery as medically necessary, and to oppose insurer policies that misclassify such surgery as cosmetic. (Directive to Take Action)

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

Received: 4/18/26

REFERENCES

1. Martinez-Thompson JM, Diehl NN, Holmes JM, Mohney BG. Incidence, types, and lifetime risk of adult-onset strabismus. Ophthalmology. 2014;121(4):877–882.
2. Pineles SL, Repka MX, Yu F, Lum F, Coleman AL. Risk of musculoskeletal injuries, fractures, and falls in Medicare beneficiaries with disorders of binocular vision. JAMA Ophthalmology. 2015;133(1):60–65.
3. Hatt SR, Leske DA, Kirgis PA, et al. The effects of strabismus on quality of life in adults. Am J Ophthalmol. 2007;144(4):643–647.
4. Liebermann L, Hatt SR, Leske DA, Holmes JM. Improvement in specific function-related quality-of-life concerns after strabismus surgery in nondiplopic adults. J AAPOS. 2014;18(2):105–109.
5. Pineles SL, Demer JL, Isenberg SJ, Birch EE, Velez FG. Improvement in binocular summation after strabismus surgery. JAMA Ophthalmology. 2015;133(3):326–332. (Demonstrates restoration of binocular vision and functional acuity.)
6. Kushner BJ. The functional benefits of strabismus surgery. J Binocul Vis Ocul Motil. 2018;68(2):59–62. (Reviews functional—not cosmetic—indications and outcomes.)
7. American Academy of Ophthalmology (AAO). Adult Strabismus Preferred Practice Pattern®. Ophthalmology. 2024;131(4):P306–P403.

RELEVANT AMA POLICY

Coverage for Strabismus Surgery H-185.957

Our American Medical Association supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-26)

Introduced by: Medical Student Section

Subject: Health Insurance Coverage of Hearing Devices and Related Services

Referred to: Reference Committee A

Whereas, of the approximately 28.8 million adults in the United States who could benefit from hearing devices, fewer than 20% use them, demonstrating a significant gap in utilization[1]; and

Whereas, research has shown that working-age adults (18-64 years) with untreated hearing loss experience adverse outcomes compared to those with normal hearing, including a 40% higher risk of death even after adjusting for confounding factors, greater social-situational limitations, higher rates of psychological distress, and an increased risk of dementia[2-5]; and

Whereas, the use of hearing aids has been shown to decrease difficulties in communication and social interaction among individuals after initiating use, and compared to adults with untreated hearing loss, adults who use hearing aids have decreased mortality, psychological distress, and risk of dementia[2,4,6,7]; and

Whereas untreated hearing loss among working-age adults has been associated with an estimated $193.8 billion in lost population income and $28.6 billion in unrealized federal tax revenue annually, while the use of hearing aids has been estimated to mitigate individual income loss of up to $22,000 per year[8]; and

Whereas, hearing devices and related audiological services, including diagnostic testing, fitting, and regular replacements, are inconsistently covered across private insurance plans and are typically excluded under Medicaid, making them inaccessible to many low-income adults[9-11]; and

Whereas, out-of-pocket costs for hearing aids and related services are unaffordable for 77% of Americans with functional hearing loss, and consumer surveys demonstrate that willingness to adopt hearing aids would more than double if insurance contributed to or fully covered the cost[10]; and

Whereas, adults with similar degrees of hearing loss and at least partial health insurance coverage for hearing aids are significantly more likely to acquire these devices than those without coverage, indicating that out-of-pocket cost is a barrier to adoption[16]; and

Whereas, adults with untreated hearing loss incur approximately $3,536 more in total healthcare spending over an 18-month span compared to those without hearing loss, while the average cost of hearing aids and related services is estimated to be $2,500, demonstrating that modest investments in coverage can yield meaningful healthcare savings[10,13]; therefore be it

RESOLVED, that our American Medical Association support public and private health insurance coverage of hearing services and devices, including digital hearing aids and routine replacements, for hearing-impaired adults aged 18-64. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/20/2026

REFERENCES

1. Deafness NI, Disorders OC. *Quick Statistics about Hearing, Balance, & Dizziness*. U.S. Department of Health and Human Services; 2024. https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing#11
2. Choi JS, Adams ME, Crimmins EM, Lin FR, Ailshire JA. Association between hearing aid use and mortality in adults with hearing loss in the USA: a mortality follow-up study of a cross-sectional cohort. *The Lancet Healthy Longevity*. 2024;5(1):e66-e75. doi:10.1016/s2666-7568(23)00232-5
3. Monzani D, Galeazzi GM, Genovese E, Marrara A, Martini A. Psychological profile and social behaviour of working adults with mild or moderate hearing loss. *Acta Otorhinolaryngologica Italica*. 2008;28(2):61. PMID: 18669069
4. Bigelow RT, Reed NS, Brewster KK, et al. Association of Hearing Loss With Psychological Distress and Utilization of Mental Health Services Among Adults in the United States. JAMA Network Open. 2020;3(7):e2010986. doi:10.1001/jamanetworkopen.2020.10986
5. Livingston G, Huntley J, Sommerlad A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet*. 2020;396(10248):413-446. doi:10.1016/s0140-6736(20)30367-6
6. Laakso M, Lipsanen J, Pajo K, et al. Working-age first-time hearing aid users' self-reported outcomes. International Journal of Audiology. 2022;62(9):877-885. doi:10.1080/14992027.2022.2106454
7. Cantuaria ML, Pedersen ER, Waldorff FB, et al. Hearing Loss, Hearing Aid Use, and Risk of Dementia in Older Adults. JAMA Otolaryngology–Head & Neck Surgery. 2024;150(2):157. doi:10.1001/jamaoto.2023.3509
8. Huddle MG, Goman AM, Kernizan FC, et al. The Economic Impact of Adult Hearing Loss: A Systematic Review. JAMA Otolaryngol Head Neck Surg. 2017;143(10):1040-1048. doi:10.1001/jamaoto.2017.1243
9. Arnold ML, Heslin BJ, Dowdy M, et al. Longitudinal Policy Surveillance of Private Insurance Hearing Aid Mandates in the United States: 1997–2022. *American Journal of Public Health*. 2024;114(4):407-414. doi:10.2105/ajph.2023.307551
10. Jilla AM, Johnson CE, Huntington-Klein N. Hearing aid affordability in the United States. *Disability and Rehabilitation: Assistive Technology*. 2023;18(3):246-252. doi:10.1080/17483107.2020.1822449
11. Planey AM. Audiology Service Accessibility and the Health Policy Landscape. *The Hearing Journal*. 2019;72(4):10,13. doi:10.1097/01.hj.0000557744.28152.45
12. Pierre JJ, Yang AW, Riley CA, Tolisano AM. The Impact of Financial Coverage on Hearing Aid Utilization Rates Within the Military Health System. Laryngoscope. 2025;135(6):2134-2138. doi:10.1002/lary.32013
13. Simpson AN, Simpson KN, Dubno JR. Higher Health Care Costs in Middle-aged US Adults With Hearing Loss. JAMA Otolaryngology-Head & Neck Surgery. 2016;142(6):607. doi:10.1001/jamaoto.2016.0188

RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929

Our American Medical Association supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia.
Our AMA works with interested state medical associations to support coverage of hearing exams, hearing aids, cochlear implants, and aural rehabilitative services by appropriate physician-led teams, in Medicaid and CHIP programs and any new public payers. [CMS Rep. 6, I-15 Appended: Res. 124, A-19 Appended: CMS Rep. 02, A-23 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 102, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-26)

Introduced by: Medical Student Section, Florida, Oklahoma, South Carolina, Tennessee

Subject: Opposing Alternative Funding Programs

Referred to: Reference Committee A

Whereas, Alternative Funding Programs (AFPs) are employer- or third-party vendor- benefit designs that exclude expensive medications from insurance formularies and instead require beneficiaries to enroll in manufacturer/charitable assistance programs or cover the costs themselves, thereby shifting liability outside the insurance benefit[1,10]; and

Whereas, AFPs divert limited manufacturer and charitable patient assistance funds away from uninsured and underinsured populations for whom they were intended, raising concerns about equity and sustainability of charitable assistance programs[2]; and

Whereas, in *AbbVie v. Payer Matrix*, AbbVie alleges that AFP models are misrepresenting insured patients as uninsured in a “fraudulent and deceptive scheme” to access manufacturer assistance funds, demonstrating increasing legal and regulatory scrutiny over these programs[17]; and

Whereas, as AFP adoption has grown rapidly, many patients are unaware of enrollment until coverage is denied, unexpected medical bills arrive, or medications are suddenly switched, disrupting continuity of care and undermining the physician-patient relationship[5,7]; and

Whereas, patients routed through AFPs experience significant barriers to care, including average treatment delays of 68 days to therapy, with 88% reporting associated stress or anxiety and 24% reporting worsening of their condition[6]; and

Whereas, AFPs have raised concerns regarding compliance under federal statutes, including the Affordable Care Act, the Employee Retirement Income Security Act, HIPAA, and the Anti-Kickback Statute, due to benefit misclassification, unauthorized data-sharing, and misaligned financial incentives[8,9]; and

Whereas, AFPs often circumvent Affordable Care Act regulations by reclassifying the medications as non-essential health benefits, which shifts cost liability onto patients or undermine cost-sharing safeguards by preventing copay from counting toward deductibles/out-of-pocket limits[10]; and

Whereas, copay adjustment programs, which seek to limit plan sponsor exposure to prescription drug costs by raising patient out of pocket costs, have been addressed by a growing number of state bans, so AFPs have emerged as a loophole achieving a similar effect, evading existing bans and regulations to continue affecting patient costs[3,4,16]; and

Whereas, national patient and provider organizations, including the CancerCare-led Alternative Funding Task Force, PAN Foundation, and Alliance for Patient Access, have publicly opposed AFPs and urged federal action to treat covered prescription drugs as essential health benefits

across markets and to prohibit plan designs that require enrollment in third-party assistance as a condition of coverage[11,12,13,14]; therefore be it

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs and advocate for federal and state legislation and regulation prohibiting their use. (New HOD Policy)

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

Received: 04/20/2026

REFERENCES

1. Doxey P. and Balicki C. The Present and Future of Alternative Funding Programs for Specialty Drugs. Washington, D.C. Leavitt Partners, LLC; 2024. Accessed August 31, 2025. https://leavittpartners.com/wp-content/uploads/2024/08/Brief_Alternative_Funding_Programs_August_2024.pdf
2. Blum K. Panel: Alternative Funding for Pharmaceuticals Brings Numerous Risks. Grapevine, TX. Speciality Pharmacy Continuum; 2023. Accessed August 31, 2025. https://www.specialtypharmacycontinuum.com/Online-First/Article/09-23/Panel-Alternative-Funding-for-Pharmaceuticals-Brings-Numerous-Risks/71521
3. An Overview of Copay Maximizers and Accumulators. Pharmacy Healthcare Solutions, LLC; 2024. Accessed August 31, 2025. https://phslrx.com/an-overview-of-copay-maximizers-and-accumulators/
4. Mahmood A. and Markiewicz S. Still on the Rise: Deductible Accumulators and Copay Maximizers in 2024. IQVIA; 2025. Accessed August 31, 2025. https://www.iqvia.com/locations/united-states/blogs/2025/04/still-on-the-rise-deductible-accumulators-copay-maximizers-in-2024
5. Alternative funding: Real savings or real problems?. Optum for Business; Accessed August 31, 2025. https://business.optum.com/en/insights/alternative-funding-savings-problems.html
6. Wong, W. B., et al. A descriptive survey of patient experiences and access to specialty medicines with alternative funding programs. *J Manag Care Spec Pharm.* 2024;30(11):1308-1316. doi: 10.18553/jmcp.2024.30.11.1308
7. Fein A. J. Employers Expand Use of Alternative Funding Programs—But Sustainability in Doubt as Loopholes Close. Drug Channels; 2023. Accessed August 31, 2025. https://www.drugchannels.net/2023/05/employers-expand-use-of-alternative.html
8. Sadid S. and Niles A. Alternative Funding Programs Affect Our Most Vulnerable Patient Populations. Pharmacy Times; 2023. Accessed August 31, 2025. https://www.pharmacytimes.com/view/alternative-funding-programs-affect-our-most-vulnerable-patient-populations
9. ERISA and IRS Compliance Related Issues for Alternative Funding Program. Vivio Health; 2024. Accessed August 31, 2025. https://viviohealth.com/wp-content/uploads/2024/07/Compliance-Issues-Alternative-Funding.pdf
10. American Medical Association. Issue Brief: Alternative Funding Programs. AMA; 2025. Accessed August 31, 2025. https://www.ama-assn.org/system/files/issue-brief-alternative-funding-programs.pdf
11. CancerCare Alternative Funding Task Force. Follow-Up Letter on Alternative Funding Programs: 2025 Notice of Benefit and Payment Parameters. CancerCare; May 31, 2024. Accessed August 31, 2025. https://media.cancercare.org/documents/375/original/Follow-Up-Letter-2025-NBPP_AFP-Taskforce-5.31.2024-FINAL.pdf
12. Feinberg BA. Alternative Funding Programs in 2024: A Hotspot for Concern and Action. *Oncology Practice Management*. February 2024;14(2). Accessed August 31, 2025. https://oncpracticemanagement.com/issues/2024/february-2024-vol-14-no-2/afps-in-2024-a-hotspot-for-concern-and-action
13. Alliance for Patient Access. Alternative Funding Programs and Rare Disease: Policy One-Pager. AfPA; December 2024. Accessed August 31, 2025. https://allianceforpatientaccess.org/wp-content/uploads/2024/12/AfPA_Rare-Disease-AFPs_One-Pager_Dec-2024.pdf
14. PAN Foundation. Our Position: Ban Copay Accumulator, Maximizer, and Alternative Funding Programs. PAN Foundation; 2025. Accessed August 31, 2025. https://www.panfoundation.org/our-positions/ban-copay-accumulator-maximizer-alternative-funding-programs/
15. Avalere Health. State Copay Accumulator Bans Now Affect 16% of Commercial Lives. Avalere; 2024. Accessed August 31, 2025. https://advisory.avalerehealth.com/insights/state-copay-accumulator-bans-now-affect-16-of-commercial-lives
16. Maas A. Alleging 'Fraudulent and Deceptive Scheme,' AbbVie Files Lawsuit Against Alternate Funding Company Payer Matrix. *AIS Health/MMIT*; May 11, 2023. Accessed August 31, 2025. https://aishealth.mmitnetwork.com/blogs/spotlight-on-market-access/alleging-fraudulent-and-deceptive-scheme-abbvie-files-lawsuit-against-alternate-funding-company-payer-matrix

RELEVANT AMA POLICY

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

H-165.846 Adequacy of Health Insurance Coverage Options
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. [CMS Rep. 7, A-07; Reaffirmation I-07, Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-26)

Introduced by: Association for Clinical Oncology, American Society of Hematology, American College of Rheumatology

Subject: Patient Continuity Protections During Payer, PBM Changes

Referred to: Reference Committee A

Whereas, specialized and complex chronic treatment regimens rely on strict adherence to clinical cycles where even a 14-day gap in therapy can result in irreversible loss of disease control, yet patients often face sudden disruptions when their payer or pharmacy benefit manager (PBM) undergoes corporate mergers, acquisitions, or contract changes; and

Whereas, these involuntary switches frequently result in the immediate cancellation of existing prior authorizations or forced non-medical switching to new preferred formularies—practices specifically opposed by the Association for Clinical Oncology 2026 Advocacy Priorities and the American Society of Hematology 2024 Access to Hematology Care in an Age of Innovation Policy Statement; and

Whereas, current AMA policy supports authorization longevity but does not explicitly mandate transition-of-care protections during corporate health plan or PBM restructuring; therefore be it

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including prior authorizations and formulary status, must be honored without interruption (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that these 90-day protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care. (Directive to Take Action)

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

Received: 4/20/26

REFERENCES

1. Association for Clinical Oncology. ASCO Prepares for 2026 State Legislative Session. December 2025. https://www.asco.org/news-initiatives/policy-news-analysis/asco-prepares-2026-state-legislative-session
2. American Society of Hematology. Access to Hematology Care in an Age of Innovation. April 2024. https://www.hematology.org/advocacy/policy-statements/2019/access-to-hematology-care-in-an-age-of-innovation
3. Federal Trade Commission. FTC Secures Landmark Settlement with Express Scripts. February 2026.
4. Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. Congress Passes Landmark PBM Reform in 2026 Spending Bill. February 2026.
5. National Comprehensive Cancer Network. NCCN Guidelines Updates Heading Into 2026. January 2026. https://www.nccn.org/guidelines/recently-published-guidelines

RELEVANT AMA POLICY

H-320.939 Prior Authorization and Utilization Management Reform
Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation... 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes. [CMS Rep. 08, A-17; Reaffirmed: A-26]

H-125.991 Drug Formularies and Therapeutic Interchange
It is the policy of the AMA that drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings... provided they satisfy the following standards: (viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute... 2. That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process. [Res. 505, A-12; Reaffirmed: 2025]

H-125.979 Private Health Insurance Formulary Transparency
Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year... and forbidding insurance carriers from making formulary deletions within the policy term. [CMS Rep. 5, A-09; Reaffirmed: 2024]

D-110.987 The Impact of Pharmacy Benefit Managers on Patients and Physicians
Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports improved transparency of PBM operations, including disclosing... records describing why a medication is chosen for or removed in the P&T committee's formulary. [CMS Rep. 5, A-19; Reaffirmed: 2025]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:116
(A-26)

Introduced by: American Academy of Pediatrics

Subject: Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs

Referred to: Reference Committee A

Whereas, the Medicaid program provides health coverage to more than 80 million Americans and represents one of the largest sources of public health care spending in the United States;[1] and

Whereas, states administer Medicaid through multiple delivery models, including state-administered fee-for-service programs, primary care case management models, and contracts with private managed care organizations (MCOs);[2] and

Whereas, as of recent federal analyses, the majority of Medicaid beneficiaries receive coverage through Medicaid managed care plans operated by private insurers under contracts with state governments;[3] and

Whereas, Medicaid managed care programs are often intended to improve care coordination, increase budget predictability for states, and promote efficient use of health care services;[4] and

Whereas, While the shift to MCOs has increased budget predictability for states, the evidence about the impact of managed care on access to care and costs is both limited and mixed;[5] and

Whereas, federal oversight agencies have identified challenges in evaluating the total costs of Medicaid managed care programs due to variations in state reporting practices and contract structures;[6] and

Whereas, physicians and health systems participating in Medicaid managed care programs frequently report significant administrative burdens associated with plan participation, including prior authorization requirements, credentialing processes, network contracting, and claims administration;[7] and

Whereas, a clearer understanding of the total fiscal and administrative implications of Medicaid managed care compared with state-administered Medicaid models would inform policymakers, physicians, and patients as states consider program design and oversight; therefore be it

RESOLVED, That our American Medical Association study and report back to the HOD at I-26 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
- Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
- The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration. (Directive to Take Action)

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

Received: 4/21/26

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicaid & CHIP Enrollment Data Highlights.
2. Medicaid and CHIP Payment and Access Commission. Provider payment and delivery systems https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/
3. Kaiser Family Foundation. Medicaid Managed Care Market Tracker. https://www.kff.org/data-collections/medicaid-managed-care-tracker/
4. Medicaid and CHIP Payment and Access Commission. Managed care's effect on outcomes https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/
5. Kaiser Family Foundation. 10 Things to Know about Medicaid Managed Care https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/
6. U.S. Government Accountability Office. Medicaid Managed Care: Additional Oversight Needed of Payments and Program Integrity. https://www.gao.gov/products/gao-14-341
7. American Medical Association. 2023 AMA Prior Authorization Physician Survey.

RELEVANT AMA POLICY

Monitoring Medicaid Managed Care H-290.985

As managed care plans increasingly become the source of care for Medicaid beneficiaries, Our American Medical Association advocates the same policies for the conduct of Medicaid managed care that our AMA advocates for private sector managed care plans. In addition, our AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

1. Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
2. Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
3. Geographic dispersion and accessibility of participating physicians and other providers.
4. Education of beneficiaries regarding appropriate use of services, including the emergency department.
5. Availability of off-hours, walk-in primary care.
6. Coverage for clinically effective preventive services.
7. Responsiveness to cultural, language and transportation barriers to access.
8. In programs where more than one plan is available, beneficiary freedom to choose their plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
9. Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
10. Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
11. Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
12. Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
13. Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
14. Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
15. Preservation of private right of action for physicians and other providers and beneficiaries.
16. Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
17. Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
18. Absence of gag rules.
19. Fairness in procedures for selection and deselection.

20. Realistic payment levels based on costs of care and predicted utilization levels.
21. Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
22. Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.

Mandatory Enrollment of Medicare-Medicaid Patients in Managed Care Plans H-290.984
The AMA, in keeping with its support for free market competition among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Universal Out of Network Benefits

Referred to: Reference Committee A

Whereas, private health insurers have deliberately used their regional monopoly powers to push unacceptably low rates on physicians, thus creating artificially narrow networks; and

Whereas, such practice creates the appearance of physician shortages and lack of access to physicians in a reasonable time, all to the sole benefit and profit of insurers; and

Whereas, before insurers created restrictive networks, healthcare costs and premiums were much lower; and

Whereas, laws that require insurers to allow patients to seek an out-of-network physician when appropriate will always be entirely inadequate because insurers will always determine that a patient does not need an out-of-network physician; and

Whereas, the now frequent need to wait months to see a physician would largely resolve if patients all had out-of-network benefits and could see any practicing physician; and

Whereas, many states are now taking the absurd step of trying to allow nurses and physician assistants to practice medicine independently because there aren't enough in-network doctors available to care for patients; and

Whereas, the practice of creating and restricting networks has coincided with a massive increase of overall healthcare costs, not a savings; and

Whereas, the single and only beneficiary of insurance policies that offer no out-of-network benefits are the insurance companies themselves, to no clear public advantage; therefore be it

RESOLVED, that our American Medical Association will advocate for state and federal laws and regulations that require all insurers to offer plans that include out-of-network benefits. (Directive to Take Action)

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

Received: 4/20/26

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:
    a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
    b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
    c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
    d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
    e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
    f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
    g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
    h. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmed: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Res. I-23; Reaffirmed: CMS Rep. 3, I-23; Reaffirmed: CMS Rep. 08, A-24

Patient Access to Covered Benefits Ordered by Out-of-Network Physicians D-285.958

1. Our American Medical Association will develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability.
2. Our AMA will collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

Citation: Res. 245, A-24

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Citation: Res. 108, A-17

Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963
Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.
Citation: Res. 119, A-15

Out of Network Restrictions of Physicians H-285.907
Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.
Citation: Res. 126, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-26)

Introduced by: American College of Rheumatology

Subject: Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

Referred to: Reference Committee A

Whereas, emerging state proposals to implement international reference pricing (IRP) seek to cap reimbursement for physician-administered drugs without ensuring alignment with acquisition costs; and

Whereas, such policies would risk creating negative margins for physician practices; and

Whereas, such misalignment between reimbursement and acquisition cost may force physicians, particularly in community-based and independent practices, to limit or cease offering in-office therapies; and

Whereas, a limitation or cessation of in-office therapies would reduce patient access to timely and appropriate care; and

Whereas, these policies may disproportionately impact patients with complex and chronic conditions by shifting care to higher-cost or less accessible settings; and

Whereas, international reference pricing models in other countries typically include broader health system policies and negotiation mechanisms not present in state-based proposals; and

Whereas, the American Medical Association (AMA) has established policy that any use of international price indices must preserve patient access to medications and limit burdens on physician practices; and

Whereas, existing AMA policy does not include specific advocacy goals to reduce the potential financial and administrative burdens of international reference pricing on physician practices; therefore be it

RESOLVED, that our American Medical Association remain committed to the position that international price indices or averages should not be used in isolation to set or determine prescription drug prices or payments (New HOD Policy); and be it further

RESOLVED, that our AMA work with state medical societies and specialty societies to educate policymakers on the risks of misaligned reimbursement under international reference pricing models and to promote approaches that reduce drug costs without jeopardizing patient access or practice sustainability (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-110.980 by addition to read as follows:

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
    g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
    h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
    i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
    b. The use of any international drug price index or average should preserve patient access to necessary medications.
    c. The use of any international drug price index or average should limit burdens on physician practices <u>by:</u>
        1. <u>Ensuring reimbursement at or above acquisition cost for physician-administered drugs.</u>
        2. <u>Protecting patient access to in-office treatments.</u>
        3. <u>Avoiding shifting care to higher-cost settings.</u>
        4. <u>Minimizing administrative and financial burdens on physician practices.</u>
    d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (Modify Current HOD Policy)

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

Received: 4/21/26

RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
    g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
    h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
    i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
    b. The use of any international drug price index or average should preserve patient access to necessary medications.
    c. The use of any international drug price index or average should limit burdens on physician practices.
    d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22