

Reference Committee B

Report(s) of the Board of Trustees

- 08 Council on Legislation Sunset Review of 2016 House Policies
- 12 The Uniform Health-Care Decisions Act
- 13 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes
- 14 Binding Arbitration in Health Insurance Contracts
- 15 Protecting the Prescriptive Authority of Plenary Licensed Physicians
- 19 Root Cause Analysis of the Causes of the Decline of Private Medical Practice
- 21 Abolishing Venue Shopping
- 24 AMA Advocacy to Mitigate Medicaid Cuts
- 25 Federal Legislation to Prohibit the Corporate Practice of Medicine
- 27 Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
- 28 Accountability in the Use of Augmented Intelligence for Prior Authorization

Resolutions

- 201 Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
- 202 Using and Defining “Unsupervised Practice of Medicine”
- 203 Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
- 204 D-400.982 Revision
- 205 Repeal of the Merit-Based Incentive Payment System (MIPS)
- 206 Overall Hospital Quality Star Ratings / CMS Star Ratings
- 207 Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
- 208 Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
- 209 Protecting Mental Health Treatment Privacy in Legal Proceedings
- 210 Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
- 211 Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
- 212 Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
- 213 Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
- 214 Medical Student Loans Should Not Be Capped
- 215 Oppose Medicare Efficiency Adjustments
- 216 Protecting Healthcare as a Sensitive Location
- 217 Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
- 218 Opposing the Practice of Jury Anchoring in Medical Liability Cases
- 219 Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
- 220 Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians

- 221 Universal Newborn Congenital Cytomegalovirus Screening
- 222 Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
- 223 Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
- 224 Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
- 225 Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
- 226 Impact of a Proposed \$100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System
- 227 Standby Capacity Payments and Health IT for Hospitals in Rural Areas
- 228 Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
- 229 Physicians are not Providers
- 230 Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
- 231 Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
- 232 Banning Flavored Cannabis E-Cigarettes
- 233 Banning Synthesized, Purified or Derivative Products from Kratom
- 234 Physician Unity in Advocacy Regarding Physician Reimbursement
- 235 Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
- 236 Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
- 237 "Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan"
- 238 Prohibiting the Independent Practice of Medicine by Artificial Intelligence
- 239 Medicare Administrative Contractor Policy Modification
- 240 Ending Private Equity Dividend Recapitalization in Healthcare
- 241 Strengthening Our AMA Efforts Toward CPOM Prohibition
- 242 Reducing Emergency Department Boarding through Payment Reform
- 243 Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
- 244 Eliminate Administrative Barriers to Appeal Wrongful Denials
- 245 State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA
- 246 Artificial Intelligence Scope of Practice
- 247 Comprehensive ERISA Reform

REPORT OF THE BOARD OF TRUSTEES

BOT Report 08-A-26

Subject: Council on Legislation Sunset Review of 2016 House Policies

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
6 1. As the House of Delegates (HOD) adopts policies, a maximum 10-year time horizon shall
7 exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain
8 it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the HOD identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way
21 for the HOD to handle the sunset reports.
22
23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
25 policy, or has been accomplished.
26
27 4. The AMA councils and the HOD should conform to the following guidelines for sunset:
28 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD
31 Reference Manual: Procedures, Policies and Practices.
32
33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-125.993	Medicare Part D Guidelines	Our AMA will continue to advocate to CMS, and if appropriate, to the United States Pharmacopeia, our AMA’s Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) with respect to drug categories and classes to be covered under Medicare Part D.	Retain – this policy remains relevant.
D-140.968	Standardized Advance Directives	Our AMA will endorse the “Uniform Health-Care Decisions Act,” which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 1993, and work with our state medical societies to advocate for its adoption in the states.	Sunset this policy. The 1993 Uniform Health-Care Decisions Act from the Uniform Law Commission has been withdrawn and replaced with a more recent version. Also see Board of Trustees Report 12-A-26, which discusses this topic.
D-165.989	Managed Care Organization Reimbursement Formulas	Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.	Retain – this policy remains relevant.
D-185.982	Health Coverage for Nutritional Products for Inborn Errors of Metabolism	Our AMA: (1) will support legislation mandating insurance coverage with minimal deductible or copays for specialized medical food products used to treat inborn errors of metabolism; and (2) will advocate with the Department of Health and Human Services and members of Congress for the regulation of specialized nutritional products for the medical treatment of inborn errors of metabolism as drugs.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
D-185.993	Advocacy for Repeal of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL)	Our AMA will support state and specialty medical societies and the public health associations in their efforts to secure repeal of laws and state insurance codes which allow for the denial of insurance payments for the treatment of injuries sustained as a consequence of the insured person being intoxicated due to alcohol or under the influence of narcotics.	Retain – this policy remains relevant.
D-190.977	Insurance Reimbursements	Our AMA will: (1) seek legislation requiring managed care companies and any third party carrier including Medicare to request a refund from physicians in the same time period they give physicians to file a claim in the contract; and (2) seek legislation that managed care companies and any third party carrier including Medicare in no case be allowed more than 180 days to request a refund from a physician.	Retain – this policy remains relevant.
D-270.990	Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians	Our AMA will pursue all appropriate legislative, regulatory and legal actions to counter expansions of the scope of work by PhD clinical lab scientists and other non-physician laboratory personnel to authorize the independent practice of medicine by any individual who has not completed the state’s requirements for licensure to engage in the practice of medicine.	Retain – this policy remains relevant.
D-290.998	Medicare/Medicaid Dual Eligibles	Our AMA will pursue all appropriate measures including, but not limited to, the development and passage by Congress of legislation to require the federal government to directly provide or mandate that states provide full reimbursement for Medicare deductibles and co-	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		payments for all patients who are Medicare/Medicaid dual eligible.	
D-305.972	Title VII Funding	Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of \$300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.	Retain – this policy remains relevant.
D-330.904	Opposition to the CMS Medicare Policies That Undermine Access to the Best Course of Treatment Part B Drug Payment Model	<p>1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.</p> <p>2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.</p> <p>3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.</p> <p>4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that</p>	<p>Retain in part and modify the title.</p> <p>Sunset clauses 1 and 2; retain clauses 3 and 4. The AMA submitted a letter to Centers for Medicare & Medicaid Services (CMS) in May 2016 on the proposed Part B Drug Payment Model. Due to strong opposition, CMS did not finalize this model in 2016.</p>

Policy Number	Title	Text	Recommendation
		impacts patient access to medical therapies, including policies on coverage and reimbursement.	
D-330.905	Expedited Review for Clerical Errors on Medicare Enrollment Applications	<ol style="list-style-type: none"> 1. Our AMA will urge the Centers for Medicare & Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician’s billing privileges. 2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake. 3. Our AMA will urge CMS to create a process that not only reactivates a physician’s billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame. 	Retain – this policy remains relevant.
D-330.906	Minimize Provider Burden for Meaningful Use Audit	<ol style="list-style-type: none"> 1. Our AMA will advocate for all audit programs to have a “look back period” of no more than two years. 2. Our AMA will advocate against the “zero tolerance” policy of the current “Meaningful Use” audit program and any similar programs proposed by the Centers for Medicare and Medicaid Services, whereby physicians lose their total incentive payment rather than receive a payment proportional to their success. 3. Our AMA will advocate to reform the Centers for Medicare and Medicaid Services “Meaningful Use” audit program. 	<p>Sunset this policy.</p> <p>This policy is tied to the Centers for Medicare & Medicaid Services “Meaningful Use” program, which no longer exists in its original form. The Meaningful Use incentive program for physicians ended years ago and was folded into the Merit-based Incentive Payment System under MACRA.</p>
D-335.982	Statute of Limitations for	Our AMA will work with Medicare to reduce the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Medicare and RAC “Lookbacks”	“Lookback” period to be no longer than the length of time allowed to submit a claim for consideration.	
D-35.979	Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices	<p>1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented.</p> <p>2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans’ medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same.</p> <p>3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and <u>other non-physicians in unsupervised practice.</u> comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.</p> <p>4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA’s proposed rulemaking expanding the role of APRNs and <u>other non-physicians within the VA in unsupervised practice.</u></p>	<p>Retain this policy with amendments.</p> <p>Clauses 3 and 4 should be amended.</p>
D-355.996	Limitations on Reports by Insurance Carriers to	1. Our AMA will seek legislation and/or regulation that would require the Health Resources and	Retain in part.

Policy Number	Title	Text	Recommendation
	<p>the National Practitioner Data Bank Unrelated to Patient Care</p>	<p>Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services.</p> <p>2. Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's settlement of a claim that included the names of those physicians in their administrative roles at the entity.</p> <p>3. Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.</p> <p>4. Our AMA will provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.</p>	<p>Clause 4 has been accomplished and can be deleted. Board of Trustees Report 04-I-17 on this subject was included in the 2017 Interim Meeting House of Delegates Handbook.</p> <p>Clauses 1-3 remain relevant.</p>
<p>D-390.951</p>	<p>CMS Revalidation of Medicare Billing Privileges</p>	<p>Our AMA will advocate for the Centers for Medicare & Medicaid Services (CMS) to adopt the practice of sending revalidation notices to physicians using certified mail with return receipt, thus ensuring that such notices are actually sent by CMS and received by the physician.</p>	<p>Sunset this policy.</p> <p>The Centers for Medicare & Medicaid Services has moved toward an electronic, self-service model. Notices are now sent by email in addition to U.S. mail, due dates are posted publicly months in</p>

Policy Number	Title	Text	Recommendation
			<p>advance, and PECOS is the primary mechanism for managing enrollment. Advocating specifically for certified mail with return receipt does not align with CMS' current direction and would likely be viewed as inconsistent with the agency's push toward modernization and paperless processes.</p>
D-440.929	Nominations for and Improvement of the Position of the United States Surgeon General	Our AMA will convey to the Presidential Transition Team support for an enhanced role for the Surgeon General in addressing important matters of public health.	<p>Sunset this policy.</p> <p>This directive has been accomplished. In 2016, the AMA met with presidential transition teams of both major party candidates to discuss their positions on a wide range of health policy issues, including public health issues that could be affected by the Surgeon General. After the election, our AMA resumed discussions with the president-elect's transition team. As part of these discussions, AMA advocated for an enhanced role for the Surgeon General that includes more resources to address matters of public health.</p>
D-450.955	Remove Pain Scores from Quality Metrics	Our AMA will work with the Centers for Medicare & Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five-star rating system for nursing facilities.	Retain – this policy remains relevant.
D-478.982	Redefine "Meaningful Use"	1. Our AMA will work with the federal government and the Department of Health and Human	Sunset this policy.

Policy Number	Title	Text	Recommendation
	of Electronic Health Records	<p>Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation.</p> <p>2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.</p>	<p>“Meaningful Use” has been replaced by the Promoting Interoperability (PI) Program for hospitals and, for clinicians, it is now a core component of the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).</p>
D-480.967	Integration of Mobile Health Applications and Devices into Practice	<p>Our AMA will: (1) assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws; and (2) assess the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician’s potential risk of liability from the use or recommendation of mHealth apps.</p>	<p>Retain – this policy remains relevant.</p>
D-480.968	Telemedicine Encounters by Third Party Vendors	<p>1. Our AMA will develop model legislation and/or regulations <u>supports</u> requiring telemedicine services or vendors to coordinate care with the patient’s medical home and/or existing treating physicians, which includes at a minimum identifying the patient’s existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient’s consent.</p> <p>2. The model legislation and/or</p>	<p>Retain with amendments.</p>

Policy Number	Title	Text	Recommendation
		<p>regulations will also <u>Our AMA also supports</u> requiring the vendor to abide by laws addressing the privacy and security of patients' medical information</p> <p>3. Our AMA will include in that model state legislation <u>supports</u> the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.</p> <p>4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.</p>	
D-505.998	International Trade Agreements	<p>Our AMA will:</p> <p>(1) monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco;</p> <p>(2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>AMA policy; (3) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that involve the distribution and advertising of alcohol and tobacco, and other pertinent public health issues, and advocate applicable AMA policy; and (4) continue to strongly advocate for US ratification of the Framework Convention on Tobacco Control.</p>	
D-95.973	Fraudulent Use of Prescriptions	<p>Our AMA: (1) will promote the efforts for state run electronic Prescription Monitoring Programs to allow individual physicians to access records of their prescribing of opioids, for their entire panel of patients, including patient names and prescription information; and (2) will study current pathways that physicians have available to report possible fraudulent use of their prescriptions and disseminate this information throughout organized medicine.</p>	Retain – this policy remains relevant.
H-100.966	Tracking and Punishing Distributors of Counterfeit Pharmaceuticals	<p>Our AMA supports legislation making the production and distribution of counterfeit pharmaceuticals a felony.</p>	Retain – this policy remains relevant.
H-110.989	Pay for Delay Arrangements by Pharmaceutical Companies	<p>Our AMA supports: (1) the Federal Trade Commission in its efforts to stop “pay for delay” arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as “pay for delay,” illegal in the United States.</p>	Retain – this policy remains relevant.
H-120.929	Protect Individualized Compounding in	<p>Our American Medical Association will advocate that <u>supports</u> the US Food and Drug</p>	Retain with amendments.

Policy Number	Title	Text	Recommendation
	Physicians' Offices as Practice of Medicine	Administration remove <u>in excluding</u> physician offices and ambulatory surgery centers from its definition of a compounding facility.	
H-120.934	Appropriate Use of Compounded Medications in Medical Offices	Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.	Retain – this policy remains relevant.
H-175.986	Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996	The AMA will work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud or abuse.	<p>Sunset this policy.</p> <p>The intent of this policy—to protect physicians from malicious or unfounded fraud allegations—is comprehensively achieved through several AMA policies requiring a knowing and willful intent standard, preserving the government's burden of proof, and ensuring robust due process protections during fraud and abuse investigations. See AMA Policies H-175.981 Fraud and Abuse Within the Medicare System; H-175.985 - Kennedy-Kassebaum: Fraud and Abuse; H-235.965 - Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse; H-175.982 - Due Process for Physicians; H-330.943 - Physicians' Rights;</p>

Policy Number	Title	Text	Recommendation
			H-175.973 - Medicare Investigation Search and Seizure Process.
H-270.953	Tax Exemptions for Feminine Hygiene Products	Our AMA supports legislation to remove all sales tax on feminine hygiene products.	Retain – this policy remains relevant.
H-270.966	Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs	Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, “welfare”) and/or the Supplemental Nutrition Assistance Program (SNAP, “food stamps”) to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.	Retain – this policy remains relevant.
H-270.968	Preservation of Political Advocacy by Nonprofit Organizations	The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.	Retain – this policy remains relevant.
H-290.964	CMS Audits and Clawbacks	Our AMA will undertake advocacy efforts to: 1) Persuade CMS to redefine “primary care provider” for purposes of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education Reconciliation Act of 2010 (“Section 1202”). Such definition should include the current providers board certified in a specialty considered primary care;	Sunset this policy. The temporary Medicaid “fee bump” paid to primary care providers under the ACA expired at the end of 2014. Medicaid RAC audits typically look back at payments for 3-5 years, and therefore the time period for such audits related to the ACA primary care bump has passed. For RAC audit issues unrelated to the

Policy Number	Title	Text	Recommendation
		<p>or providers attesting to the 60% threshold under the same methodology as used in the parallel statutory formula in Section 5501(a) of PPACA; or, in states utilizing managed care organizations, providers who are, or have been held out by such MCOs as primary care providers by having patients assigned to such primary care providers and holding such providers out to the public as primary care providers; and the 60% Threshold formula previously utilized in attestation.</p> <p>2) Persuade CMS to order that the audits conducted, or to be conducted, of the enhanced payments to primary care physicians, by state Medicaid agencies or their agents be conducted pursuant to the amended flexible formula redefining “primary care provider.”</p> <p>3) Persuade CMS to order that state Medicaid agencies, or their agents, immediately cease recoupments, or hold amounts of funds already recouped in trust, until a new audit using the redefined formula can be completed.</p>	<p>ACA Medicaid primary care fee bump, the AMA continues to engage in advocacy to improve the RAC audit process under Policies D-320.991 - Creating a Fair and Balanced Medicare and Medicaid RAC Program, and D-330.915 - RAC Audits of E&M Codes.</p>
H-290.978	Medicare/Medicaid Dual Eligible Reimbursement	<p>Our AMA seeks the repeal of Section 4714 of the Balanced Budget Act of 1997 and restore the requirement that states pay the deductible, copayment and coinsurance amounts for Medicare/Medicaid dual-eligible patients.</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
H-330.995	Amendments to the Medicare Civil Penalties Section of the Social Security Act	The AMA supports amendment of the Social Security Act to permit trial de novo for a physician who so requests when the sum of the penalties levied is greater than \$10,000 and/or when a suspension from the Medicare program is applied.	Retain – this policy remains relevant.
H-355.974	National Practitioner Data Bank	1. Our AMA will advocate to the Health Resources and Services Administration that a physician’s surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.	Retain – this policy remains relevant.
H-370.968	Endorsement of the Uniform Anatomical Gift Act (2006)	Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA.	Retain – this policy remains relevant.
H-383.987	Restrictive Covenants in Physician Contracts	Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.	Retain – this policy remains relevant.
H-390.853	Protecting Patient Access to High Quality Imaging Services	Our AMA actively supports repeal or delay of the provision under Section 5102 of the Deficit Reduction Omnibus Reconciliation Act of 2005 that reduces the technical component payment (including the technical component of the global payment) for an imaging service under the physician payment	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>schedule if it exceeds (without regard to geographic wage adjustment factor) the outpatient department payment schedule amount for the service established under the Medicare prospective payment system for hospital outpatient departments.</p>	
H-390.898	Equity in Medicare Payment Levels	<p>Our AMA: (1) adopts as a major legislative priority the adequate funding of the Medicare program; and (2) supports the initiation of legislation to prevent any further reduction of the current Medicare limiting charges.</p>	<p>Sunset this policy.</p> <p>This policy has been superseded by AMA Efforts on Medicare Payment Reform D-400.982; Health System Reform Legislation H-165.838; Physician Payment Reform H-400.972; Sequestration D-390.946; Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program D-390.921; and Saving Traditional Medicare H-390.832.</p>
H-40.970	The Uniformed Services University of the Health Sciences	<p>The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences.</p>	<p>Retain – this policy remains relevant.</p>
H-400.989	Physician Negotiations	<p>The AMA supports federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement.</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
H-410.949	Dry Needling is an Invasive Procedure	Our AMA recognizes dry needling as an invasive procedure and maintains that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.	Retain – this policy remains relevant.
H-435.952	Savings Accounts for Extended Reporting Endorsement Policies and Other Liability Insurance Costs	Our AMA supports changes to the Internal Revenue Code to allow a pre-tax Extended Reporting Endorsement Savings Account whereby the amount of money contributed before taxes and interest on earnings from those monies be allowed to grow tax free until such time as an extended reporting endorsement must be purchased and that the balance of any remaining funds would return to the physician without IRS penalty and be subject to taxation at that time.	Retain – this policy remains relevant.
H-435.958	Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies	The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies.	Retain – this policy remains relevant.
H-435.960	Physician Relief from Product Class Actions	Our AMA: (1) asks Congress to pass legislation which prevents naming the treating physician as a party to product liability lawsuits when the treating physician has used a Food and Drug Administration-approved drug or device; and (2) promotes the introduction of legislation which would exempt physicians who have properly prescribed usage of Food and Drug Administration-approved medications from liability in class action suits	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		against pharmaceutical companies.	
H-435.967	Report of the Special Task Force and the Advisory Panel on Professional Liability	1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA’s MICRA-based federal tort reform provisions include: (a) a \$250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.	Retain – this policy remains relevant.
H-435.976	Liability Protection for Medical Volunteers	It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal.	Retain – this policy remains relevant.
H-478.985	Patient Safety Incidents Related to Use of Electronic Health Records	Our AMA supports the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center to minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses.	Sunset this policy. The Office of the National Coordinator for Health IT (ONC) efforts to implement the “Health IT Safety Center” never materialized. Instead of a centralized, independent center, ONC shifted to a collaborative approach to safety, which included SAFER (Safety Assurance Factors for Electronic Health Record Resilience) Guides, voluntary reporting, integrating safety into certification, and industry collaboration.

Policy Number	Title	Text	Recommendation
H-478.986	Merit-Based Incentive Programs	Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.	Retain – this policy remains relevant.
H-95.927	Universal Prescriber Access to Prescription Drug Monitoring Programs	Our AMA supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.	Retain – this policy remains relevant.
H-95.928	Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing	<ol style="list-style-type: none"> 1. Our AMA supports the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame. 2. Our AMA will advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care. 3. Our AMA will work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them. 4. Our AMA will advocate for the interoperability of state PDMPs 	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>with electronic health records (EHRs). 5. Our AMA will advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.</p>	
H-95.929	Support for Prescription Drug Monitoring Programs	<p>Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.</p>	<p>Sunset this policy.</p> <p>PDMPs are largely ubiquitous in states, and interstate interoperability, while not universal, is common. This policy is also covered by H-95.939 - Development and Promotion of Single National Prescription Drug Monitoring Program.</p>
H-95.939	Development and Promotion of Single National Prescription Drug Monitoring Program	<p>Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician’s normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5)</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.</p>	
H-95.986	State Legislation to Monitor Prescription of Schedule II Drugs	<p>The AMA believes that it is important for each state to assess its own drug diversion problem and, taking into consideration the strengths of various available programs, to tailor remedial action to the specific problems of the state involved.</p>	<p>Sunset this policy.</p> <p>Each state has robust policies that accomplish this. The AMA also has multiple policies addressing the need for multifaceted state and national efforts. These include: H-95.896 - Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis; and H-95.940 - Addressing Emerging Trends in Illicit Drug Use.</p>

REPORT OF THE BOARD OF TRUSTEES

BOT Report 12-A-26

Subject: The Uniform Health-Care Decisions Act
(Resolution 250-A-24)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

1 This American Medical Association (AMA) Board of Trustees (Board) report responds to the
2 referral of Board Report 13-A-25, “The Uniform Health-Care Decisions Act,” which arose from
3 Resolution 250-A-24, “Endorsement of the Uniform Health-Care Decisions Act,” introduced by the
4 Michigan Delegation which was also referred. Resolution 250-A-24 proposed amending Policy D-
5 140.968, “Standardized Advance Directives,” as follows:

6
7 Our AMA will endorse the “Uniform Health-Care Decisions Act,” which was drafted and
8 adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL)
9 in ~~1993~~ 2023, and work with our state medical societies to advocate for its adoption in the
10 states.

11
12 Testimony in support of Resolution 250-A-24 emphasized that AMA had endorsed the 1993
13 version of the Uniform Health-Care Decisions Act (UHCDA), that a new and updated version of
14 the UHCDA had been approved in 2023, and that endorsement of the 2023 version was a needed
15 update to AMA policy. Supportive testimony also praised the UHCDA’s new provisions related to
16 end-of-life care. On the other hand, other testimony voiced concern about the UHCDA provisions
17 related to mental health and expressed that the UHCDA inadequately addressed complex issues
18 that would negatively impact medical practice.

19
20 Board Report 13-A-25 examined the binary question of whether the AMA should endorse the 2023
21 UHCDA as adopted by the Uniform Law Commission (ULC) and did not seek or recommend
22 changes to the UHCDA or address broader policy issues. The report recommended against
23 endorsement of the 2023 UHCDA and recommended rescinding Policy D-140.968 as outdated.

24
25 At the 2025 Annual Meeting, testimony requested that Board Report 13-A-25 be referred back to
26 the Board for further study rather than proceeding with the recommendation to rescind AMA
27 Policy D-140.968. Testimony expressed concerns that rescinding the policy would leave the AMA
28 without guidance on standardized advance directives and urged the Board to develop affirmative
29 policy addressing advance care planning.

30
31 This report responds to the referral by clarifying the scope and intent of the Board’s prior
32 recommendations, acknowledging the concerns raised, and reaffirming the extensive body of
33 existing AMA policy that already addresses advance care planning, advance directives, surrogate
34 decision making, and related ethical and clinical issues.

1 BACKGROUND

2
3 The ULC is a nonpartisan, non-profit association comprised of state commissions on uniform laws
4 from each state. Members of the ULC are licensed attorneys. The ULC’s purpose is “to study and
5 review the law of the states to determine which areas of law should be uniform [and] promote the
6 principle of uniformity by drafting and proposing specific statutes in areas of the law where
7 uniformity between the states is desirable.”¹ Importantly, the ULC drafts model legislation, but the
8 legislation must be enacted by a state legislature to be effective.
9

10 In 1993, the ULC, then known as the National Conference of Commissioners on Uniform State
11 Laws, promulgated the UHCDA, a third-generation model bill that addressed advance health care
12 directives and health care decision-making on behalf of patients lacking capacity. Subsequently,
13 the AMA adopted policy to endorse the 1993 UHCDA. Six states (AK, HI, ME, MS, NM, and
14 WY) enacted the 1993 UHCDA. In 2020, the ULC appointed a drafting committee to modernize
15 and expand the UHCDA, and in 2023, the ULC approved the 2023 UHCDA.
16

17 The 2023 UHCDA governs powers of attorney for health care, advance directives, and other forms
18 of health care instructions intended to inform health care professionals and agents about a patient’s
19 wishes, priorities, and values regarding health care decisions made for them when they are unable
20 to make such decisions themselves. The UHCDA also governs determination of capacity, judicial
21 review, and appointment of surrogate decisionmakers when there is no advance directive. In
22 addition, the UHCDA establishes certain duties and powers of agents and health care professionals
23 and shields them from liability when they act reasonably and in good faith.
24

25 Among the changes in the 2023 UHCDA is the authorization of advance directives specifically for
26 mental health care. These directives enable individuals to provide specific instructions reflecting
27 their preferences for mental health care and/or to authorize an agent to make mental health care
28 decisions on their behalf. The provisions also allow an individual to limit their own ability to
29 revoke an advance mental health care directive when experiencing an acute mental health event.
30

31 To date, two states (DE and NV) have enacted the 2023 UHCDA.
32

33 AMA POLICY

34
35 As noted, AMA Policy D-140.968, “Standardized Advance Directives,” is narrowly focused on
36 endorsement of the 1993 UHCDA and urges state medical societies to advocate for its adoption.
37 Beyond policy on the UHCDA, the AMA maintains a robust and comprehensive set of policies that
38 address advance care planning across clinical, ethical, and public policy dimensions.
39

40 Policy H-85.957, “Encouraging Standardized Advance Directives Forms Within States,”
41 encourages state medical societies to develop a template advance directive form for use by
42 physicians and other health care providers to discuss end-of-life care with their patients.
43

44 Policy H-140.845, “Encouraging the Use of Advance Directives and Health Care Powers of
45 Attorney,” outlines the AMA’s commitment to encouraging the use and awareness of advance
46 directives and Durable Powers of Attorney for Health Care. The policy urges health care providers
47 to educate young adults, nursing home residents, physicians, and medical students about advance
48 directives and designating health care proxies. It promotes ensuring care plans, including advance
49 directives, are on file and accompany patients when transferred between facilities. The policy
50 encourages states and specialty societies to address technical issues with these documents and for
51 medical offices to make related information easily accessible. The policy calls for collaboration

1 with insurers, states, Congress, and federal agencies to expand public education, include materials
2 during Medicare enrollment and driver's license renewal, and provide incentives for advance
3 directive completion. Additionally, it supports ongoing efforts to help physicians educate patients
4 about advance directives and advocates for the secure electronic storage of these documents.

5
6 Policy H-85.956, "Educating Physicians About Advance Care Planning," supports efforts to
7 increase the prevalence and quality of meaningful advance care planning, including the use of
8 advance directives, to improve recognition of and adherence to a patient's advance care decisions,
9 the development of materials to educate physicians, patients and others about advance care
10 planning and the requirements and implications of the Patient Self-Determination Act, and patient
11 education resources. The Policy also encourages medical schools and residency programs to
12 increase awareness of advance care planning and educate trainees about the use of such tools.

13
14 Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients,"
15 outlines best practices for making decisions about life-sustaining treatment for incompetent
16 patients, emphasizing the importance of advance directives, such as living wills and designated
17 proxies, to ensure a patient's wishes are respected. If no directive exists, family or close associates
18 serve as surrogate decisionmakers, guided by the patient's known preferences or best interests;
19 physicians must provide all relevant information. The policy instructs that institutional ethics
20 committees with diverse representation should support sound decision-making, especially in
21 contentious cases requiring review. Judicial intervention should be a last resort, focused on
22 assigning decision makers rather than making treatment choices. When the patient's wishes are
23 unknown, surrogates' genuine concern should guide decisions. Special consideration and support
24 are advised for cases involving permanently unconscious patients or seriously ill newborns,
25 including parental counseling and ethics consultations. Hospitals must have protocols to guide
26 capacity assessment, surrogate identification, and dispute resolution in line with these principles.

27
28 Policy H-85.952, "Advance Directives During Pregnancy," affirms the patient-physician
29 relationship as the appropriate locus of decision making and the independence and integrity of that
30 relationship, promotes awareness and understanding of the ethical responsibilities of physicians
31 with respect to advance care planning, the use of advance directives, and surrogate decision
32 making, regardless of gender or pregnancy status, set out in the *AMA Code of Medical Ethics*, and
33 recognizes that there may be extenuating circumstances which may benefit from institutional ethics
34 committee review, or review by another body where appropriate.

35
36 Finally, AMA Policy H-140.826, "Use of Psychiatric Advance Directives," recognizes the potential
37 for advance care planning to promote the autonomy of patients with mental illness and urges the
38 mental health community to continue to study the role of advance care planning in therapeutic
39 relationships and the use of psychiatric advance directives to promote the interests and well-being
40 of patients, and support efforts to increase awareness and appropriate utilization of psychiatric
41 advance directives.

42 43 DISCUSSION

44
45 Advance care planning is an important aspect of ensuring patient treatment preferences are
46 respected in the event the patient is unable to communicate their wishes. Central to respecting
47 patient autonomy at the end of life or during incapacity is the use of advance directives, a health
48 care power of attorney, and other advance care planning instruments. However, laws governing
49 these instruments may vary across states and this inconsistency can create confusion, complexity,
50 and barriers to effective health care decision-making, ultimately undermining the very goals of
51 advance care planning. A uniform approach among state laws could help minimize confusion and

1 inconsistency and promote high-quality patient care and effective communication and decision-
 2 making between patients, families, and health care professionals, particularly in cases when
 3 medical decision-making may occur across state lines, amidst conflict between family members or
 4 when a patients’ preferences have not been made clear. The 2023 UHCDA provides a framework
 5 for the creation, execution, and recognition of advance care planning tools, the delegation of health
 6 care decision-making, and the relevant duties of agents and health care providers. Indeed, existing
 7 AMA policy aligns with the goals of the 2023 UHCDA. However, inconsistencies between the
 8 2023 UHCDA, AMA policy, and clinical practice raise concerns about AMA endorsement of the
 9 2023 UHCDA.

10
 11 One key criticism of the 2023 UHCDA centers around determinations of patient capacity to make
 12 health care decisions, and the lack of clear guidelines for complex medical scenarios. Specifically,
 13 under the 2023 UHCDA, the determination of capacity requires consideration of two criteria: (1)
 14 whether an individual is willing and able to communicate a decision and (2) whether the individual
 15 understands the nature and consequences of making or revoking a decision or instruction. In
 16 contrast, the widely accepted assessment of decisional capacity in clinical practice, which has been
 17 incorporated into state laws, assesses four skills: whether the individual is able to understand
 18 relevant information; appreciate the clinical circumstances; exhibit a rational process of decision
 19 making; and communicate a consistent choice.² While the approaches are not necessarily in
 20 conflict in all cases, the 2023 UHCDA approach could, particularly with regard to psychiatric care,
 21 conflict with the accepted medical standard for assessing capacity. This could lead to confusion
 22 among health care professionals and in application in the courts.

23
 24 Additionally, there are 2023 UHCDA provisions that directly conflict with existing AMA policy.
 25 AMA Policy H-140.970, “Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients,”
 26 states that, in the absence of an advance directive, the patient’s family should become the surrogate
 27 decisionmaker regarding decisions to forgo life-sustaining treatment, whereas the 2023 UHCDA
 28 first prioritizes “an adult the individual has identified, other than in a power of attorney for health
 29 care, to make a health-care decision for the individual if the individual cannot make the decision”
 30 before family. AMA policy also identifies when decisions to forgo life-sustaining treatment
 31 warrant institutional or judicial review, including when there is a dispute among family members
 32 and no designated decisionmaker, and when there is no available family willing to be the patient’s
 33 surrogate decisionmaker. In contrast, the 2023 UHCDA instructs health care providers to comply
 34 with the decision of a majority of the family members when there is a dispute and authorizes non-
 35 family members to function as surrogate decision makers according to a priority list. AMA policy
 36 also advocates for institutional ethics committees, whereas the 2023 UHCDA makes no mention of
 37 ethics committees. The 2023 UHCDA also authorizes and promotes mental health advance
 38 directives, whereas AMA policy merely recognizes the potential benefit of such directives and
 39 urges further study.

40
 41 The 2023 UHCDA also conflicts with AMA policies that vigorously support and advocate for
 42 appropriate physician supervision of non-physician clinical staff in all areas of medicine.
 43 Specifically, the 2023 UHCDA authorizes a “responsible health-care professional” to determine
 44 whether a patient lacks capacity when a physician, psychologist, physician assistant, advanced
 45 practice registered nurse, or social worker is unavailable, and a prompt decision is necessary to
 46 avoid loss of life or serious harm. The 2023 UHCDA does not require the “responsible health-care
 47 professional” to have any specific training, expertise, or license. AMA Policy H-160.949,
 48 “Practicing Medicine by Non-Physicians,” expressly opposes state legislation allowing non-
 49 physician groups to engage in the practice of medicine without physician training or appropriate
 50 physician supervision.

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

6
7 The Board appreciates the thoughtful testimony provided at the 2025 Annual Meeting and
8 recognizes the importance of advance care planning in ensuring that patients' treatment preferences
9 are respected. The Board acknowledges that concerns were expressed that rescinding
10 Policy D-140.968 would leave the AMA without direction on advance care planning and
11 standardized advance directives. It is important to clarify, however, the scope of Policy D-140.968
12 and the breadth of the AMA's existing policy framework. Policy D-140.968 addresses only the
13 AMA's endorsement of the 1993 UHCDA model act. Since the 1993 model act has been replaced
14 by the 2023 version, Policy D-140.968 has become obsolete and should be sunset (as
15 recommended in Board Report 8 being presented at 2026 Annual Meeting). However, sunseting
16 this policy would not leave the AMA without direction on advance care planning. The AMA
17 maintains extensive and robust policy addressing advance directives, advance care planning,
18 powers of attorney for health care, surrogate decision-making, and related issues, as detailed in the
19 AMA Policy section of this report and Board Report 13-A-25.

20
21 The Board recognizes the desire expressed in testimony for the AMA to take a leadership role in
22 crafting an alternative to the 2023 UHCDA. However, the Board must note that the ULC's
23 development of the 2023 UHCDA reflects the culmination of an intensive, multi-year process led
24 by ULC involving extensive stakeholder engagement, legal expertise, and multiple iterations of
25 drafting and revision and consideration of complex legal, ethical, and clinical issues across diverse
26 practice settings and state regulatory environments. Attempting to replicate or improve upon such a
27 comprehensive effort is beyond the scope of a Board report.

28
29 Moreover, large-scale changes to AMA policy, particularly those that would establish new
30 substantive positions or reconcile complex legal, ethical, and clinical issues, are most appropriately
31 initiated by the House of Delegates through resolutions or by Councils reports that allow for
32 thorough vetting, stakeholder input, and deliberative consideration. The Board respectfully submits
33 that it would be inappropriate for a Board report to attempt to craft new comprehensive policy on
34 these issues, as this would bypass the deliberative processes of the House of Delegates that are
35 designed to ensure thoughtful policy development with appropriate input from the Federation.

36
37 In this context, the Board believes it is important to reaffirm the AMA's existing comprehensive
38 policy framework on advance care planning, which already provides substantial guidance for the
39 AMA's advocacy work and for physicians' clinical practice. These policies address the core
40 concerns raised in testimony regarding standardized advance directives, mental health advance
41 directives, surrogate decision-making, and capacity determination, and demonstrate the AMA's
42 longstanding commitment to promoting advance care planning, respecting patient autonomy, and
43 ensuring appropriate surrogate decision-making. Reaffirmation of existing policy underscores that
44 the AMA already has extensive guidance to inform its work, while preserving the ability of the
45 House of Delegates or AMA councils to propose and consider new or revised policy in the future
46 through established processes.

1 RECOMMENDATIONS

2

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

5

6 1. That Policy H-85.957, “Encouraging Standardized Advance Directives Forms Within
7 States,” be reaffirmed. (Reaffirm HOD Policy)

8

9 2. That Policy H-140.845, “Encouraging the Use of Advance Directives and Health Care
10 Powers of Attorney,” be reaffirmed. (Reaffirm HOD Policy)

11

12 3. That Policy H-85.956, “Educating Physicians About Advance Care Planning,” be
13 reaffirmed. (Reaffirm HOD Policy)

14

15 4. That Policy H-140.970, “Decisions to Forgo Life-Sustaining Treatment for Incompetent
16 Patients,” be reaffirmed. (Reaffirm HOD Policy)

17

18 5. That Policy H-140.826, “Use of Psychiatric Advance Directives,” be reaffirmed. (Reaffirm
19 HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ “About Us”, Uniform Laws Commission, available at <https://www.uniformlaws.org/aboutulc/overview>

² Paul S. Appelbaum & Thomas Grisso, Assessing patients' capacities to consent to treatment, 319 NEJM 25, 1635-8 (Dec. 1988); Jacob M. Appel, The Statutory Codification of Decisional Capacity Standards, 51 J Am Academy Psych & Law 4, 506-519 (Dec. 2023).

REPORT OF THE BOARD OF TRUSTEES

BOT Report 13-A-26

Subject: Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

1 At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD) Resolution 209, “Reducing Risk of Federal Investigation or Prosecution for Prescribing
3 Controlled Substances for Legitimate Medical Purposes,” was introduced by the American Society
4 of Addiction Medicine and the American Academy of Hospice and Palliative Medicine. The first
5 item in the resolve of Resolution 209-A-25 was adopted and became Policy H-95.894 and calls for
6 the AMA to “support legislative, regulatory, and other advocacy efforts that advance the adoption
7 of a conjunctive standard in the context of legitimate medical purpose by an individual practitioner
8 acting in the usual course of his professional practice” under the federal Controlled Substances Act
9 and implementing regulations.”

10
11 The second item in the resolve of Resolution 209-A-25 was referred. This item asked the AMA to:
12
13 address relevant federal regulations to clarify that “legitimate medical purpose” means “for the
14 purpose of preventing, treating, or managing a patient’s health-related condition.”

15
16 This report studies the issues raised by providing relevant background, discussing issues raised by
17 the resolution, citing AMA policy, and making recommendations.

18
19 **BACKGROUND**

20
21 The term, “legitimate medical purpose,” appears multiple times in the Controlled Substances Act
22 (CSA), but the CSA does not provide a specific definition for “legitimate medical purpose.”¹
23 Regulations implementing the CSA, which are supposed to guide the U.S. Drug Enforcement
24 Administration (DEA), also do not specifically define the term.² For example, Section 1306.04 of
25 the CSA provides, in part, that “A prescription for a controlled substance to be effective must be
26 issued for a legitimate medical purpose by an individual practitioner acting in the usual course of
27 his professional practice.”³ Multiple provisions in Section 1300 (and elsewhere) in the CSA use
28 essentially the same language with respect to electronic prescriptions, prescriptions obtained via a
29 telemedicine encounter, and other situations.⁴ The CSA, however, does not actually define what
30 constitutes a “legitimate medical purpose.” Examples within the CSA’s regulatory framework that
31 mirror the CSA include:

- 32
33 • A “valid prescription” means a prescription that is issued for a legitimate medical purpose
34 by an individual practitioner licensed by law to administer and prescribe the drugs
35 concerned and acting in the usual course of the practitioner’s professional practice.”⁵

- 1 • “A prescription for a controlled substance to be effective must be issued for a legitimate
2 medical purpose by an individual practitioner acting in the usual course of his professional
3 practice.”⁶
4

5 Despite the lack of a clear definition, the term, “legitimate medical purpose,” is commonly used by
6 the DEA and the courts to identify situations that are contrary to a legitimate medical purpose.
7 Representative examples include:
8

- 9 • “[T]he Agency concludes that Respondent issued multiple controlled substance
10 prescriptions other than for a legitimate medical purpose while acting in the usual course of
11 professional practice, prescribed controlled substances without an appropriate prior
12 examination and a medical indication, and failed to maintain adequate and accurate records
13 relating to the provision of services, thus committing multiple violations of California law
14 and, therefore, of federal law.”⁷
15 • “Respondent issued prescriptions for his own personal use to feed his addiction, not for a
16 legitimate medical use.”⁸
17 • “[T]hese prescriptions were issued without a legitimate medical purpose, outside the usual
18 course of professional practice, and beneath the standard of care because Respondent failed
19 to appropriately establish or document a medical indication.”⁹
20

21 One of the purposes of the DEA Practitioner’s Manual is to provide guidance to practitioners, but
22 the manual similarly does not clarify what is—and is not—a “legitimate medical purpose.” For
23 example, the manual states that, “There is a legitimate need for controlled substances, and DEA
24 does not want to hinder their legitimate prescribing, administering, and dispensing.”¹⁰ The DEA
25 additionally tells practitioners that,
26

27 Federal controlled substance laws are designed to function in tandem with state-controlled
28 substance laws. DEA works in cooperation with state professional licensing boards and
29 state and local law enforcement officials to make certain that pharmaceutical controlled
30 substances are prescribed, administered, and dispensed for a legitimate medical purpose in
31 the usual course of professional practice.¹¹
32

33 The “tandem” nature cited by DEA also is not clearly defined, but as described in more detail below,
34 highlights the essential role that state medical boards play in regulating the practice of medicine.
35

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

1 Just as it is highly challenging to identify a specific definition for “legitimate medical practice,”
2 there does not appear to be a reliable, comprehensive source to try and understand how often
3 physicians may be subject to investigations or sanctions where “legitimate medical purpose” is
4 used. Several sources, recent and historical, provide some limited insight. The U.S. Department of
5 Justice Criminal Division, for example, reports that its “Strike Force Operations” have resulted in
6 hundreds of indictments, many of which involve charges relating to alleged inappropriate
7 prescribing of opioid analgesics and other controlled substances.¹⁶ Between 2006 and 2016, the
8 National Association of Attorneys General (NAAG) studied the cases of 378 physicians who, since
9 2006, had been charged and whose cases were resolved and/or sentences rendered by
10 Dec. 31, 2016.¹⁷ More than 300 physicians pled guilty, and of the 69 who pled “not guilty,” and
11 chose a trial, only one was acquitted. While some of those cases involved allegations concerning
12 controlled substances, a definitive number was not reported.

13
14 The standard used to evaluate and/or investigate physicians’ actions at the state level typically
15 comes from how the state medical board defines and regulates the practice of medicine. In a review
16 of the definition of “practice of medicine” from 44 states, DC, Guam, and the Northern Mariana
17 Islands, the term “legitimate medical purpose” does not appear.¹⁸ (See Appendix A, “Practice of
18 Medicine—Location Defined.”) Common terms in state definitions, however, include treat or
19 treatment; prescribe, prescribing or prescription; diagnose or diagnosis; disease, condition, prevent
20 and prevention; and other terms. The U.S. Code of Federal Regulations generally defers to state
21 law in lieu of providing a specific definition for the practice of medicine.

22
23 Similar to not knowing precisely how many physicians are investigated at the federal level for
24 allegedly failing to meet the “legitimate medical purpose” standard, it is not clear how many state
25 investigations occur because investigations are not necessarily publicly reported. With respect to
26 sanctions at the medical board level, the Federation of State Medical Boards (FSMB) report that
27 there was an average of 3,167 physicians disciplined per year between 2021 to 2024.¹⁹ The FSMB
28 information reviewed does not detail the reasons for the discipline, but one reason boards
29 investigate and discipline physician includes “prescribing drugs in excessive amounts without
30 legitimate reason.”²⁰ A cross-sectional study of 3,128 disciplinary proceedings across five states
31 (CA, FL, NY, PA, and TX) found that, “the top 5 reasons for physician discipline across all 5 states
32 were practitioner negligence (1911 [28.7 percentage]), other (1102 [16.6 percentage]), problematic
33 record-keeping (990 [14.9 percentage]), inappropriate prescribing (901 [13.5 percentage]), and
34 criminal activity (599 [9.0 percentage]).”²¹ This data, however, do not account for investigations
35 that closed without a charge, sanction or other action.

36 37 DISCUSSION

38
39 For investigations that do occur, the DEA may choose to inspect records, gain entry to the practice,
40 conduct interviews and take other actions, which are extremely disruptive to a practice. This broad
41 authority under the CSA often occurs through the use of administrative subpoenas or warrants, or
42 criminal warrants.^{22 23} These investigations by law enforcement (or medical boards) have
43 significant adverse effects on physicians. Researchers describe that investigations create “feelings
44 of anger, depression, anxiety, shame, powerlessness, isolation, being betrayed, less confidence in
45 clinical decision-making.”²⁴ Even the mere threat of an investigation being initiated can have a
46 chilling effect on a physician’s practice. Physicians also face practical effects, including the
47 potential for temporary or long-term suspension of practice, considerable financial expense,
48 disruption to providing care due to inspections and records review, and the time and legal costs to
49 properly respond to the investigation. In addition, when an investigation becomes public, whether it
50 leads to formal charges or not, there is an immediate, adverse effect on the physician’s reputation
51 in the community, including among colleagues. To be clear, the AMA does not support illegal

1 prescribing or other similar actions by physicians, but the Board of Trustees (the Board) points out
2 that the adverse effects cited above occur whether or not the investigation leads to formal charges.
3 These are some of the reasons why physicians fear the DEA and other law enforcement.

4
5 While DEA and law enforcement accurately say that they do not regulate the practice of medicine,
6 the threat of investigation is real for many physicians, particularly those who prescribe controlled
7 substances. One qualitative survey found that such fear resulted in reductions of prescribers willing
8 to provide opioid therapy, patients being removed from practices, and patients turning to illicit
9 substances if their physician no longer provided care.²⁵ It is not surprising that law enforcement
10 investigations—because they require a higher standard of proof for conviction than how a medical
11 board determines if the standard of care was met—are invasive, complicated, and time consuming
12 for all involved. Physicians describe decisions whether to prescribe opioids and other controlled
13 substances as putting them “between a rock and a hard place,” with researchers noting that
14 physicians acutely understand that, “An investigation alone can be devastating, and a finding of
15 liability can trigger a cascade of consequences that make it impossible to practice medicine.”²⁶

16
17 In the prosecutions cited above, the main question ultimately was a binary one: Did the physician
18 meet the “legitimate medical purpose” standard? The DEA, for its part, has said that it “does not
19 define or regulate the practice of medicine; instruct practitioners on what type, or what strength of a
20 Schedule II-V Controlled Substance they can or must prescribe; dictate how frequently a
21 practitioner must see a patient; [or] dictate what tests a practitioner must conduct.”²⁷ The DEA has
22 further explained that, “the types of cases in which physicians have been found to have dispensed
23 controlled substances improperly under Federal law generally involve facts where the physician’s
24 conduct is not merely of questionable legality, but instead is a glaring example of illegal activity.”²⁸
25 The DEA and courts, moreover, make their determinations on a case-by-case basis.^{29 30} A review
26 of the types of cases where a DEA registrant was found to be acting outside the course of usual
27 professional practice and where a prescription was not for a legitimate medical purpose typically
28 included multiple factors, which might include one or more of the following: high doses/quantities
29 of opioid analgesics; combination prescriptions for opioids, benzodiazepines and muscle relaxants;
30 patients who receive multiple prescriptions for controlled substances from multiple providers; and
31 unusual geographic distances.

32
33 The above factors are analyzed by the courts for determining whether to convict an individual
34 under the CSA. As noted in *Feingold* and exemplified in the NAAG data cited and other cases—
35 the facts are typically so extreme that acquittals are rare if a case is brought to trial. While there is a
36 lack of data as to how often criminal investigations occur, it is reasonable to suggest that there are a
37 far greater number of such investigations. That is, prosecutors tend to strongly prefer winnable
38 cases versus those where it was questionable that there was a deviation from “legitimate medical
39 purpose.” The U.S. Supreme Court, in *Gonzalez v. Oregon*, analyzed the relationship between the
40 CSA and a state’s authority to regulate the practice of medicine, and stated that,

41
42 The statute and our case law amply support the conclusion that Congress regulates medical
43 practice insofar as it bars doctors from using their prescription-writing powers as a means to
44 engage in illicit drug dealing and trafficking as conventionally understood. Beyond this,
45 however, the statute manifests no intent to regulate the practice of medicine generally.”³¹ In
46 *Gonzalez*, the Court found that the federal government must give extraordinary deference to
47 a state’s authority to regulate the practice of medicine, including that the U.S. Attorney
48 General “is not authorized to make a rule declaring illegitimate a medical standard for care
49 and treatment of patients that is specifically authorized under state law.”³²

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

13
14 This is not to say that a medical board investigation is any less intrusive or burdensome than one
15 conducted by law enforcement. Rather, within the scope of this report, state regulation provides a
16 more well-defined starting point to guide investigations rather than what currently is used under the
17 CSA. Even though the Board recognizes that there are differences in how states define the practice
18 of medicine, having law enforcement use state definitions would help provide a clearer distinction
19 to help law enforcement distinguish between practices by clinicians that do not have a “legitimate
20 medical purpose” from clinicians whose practices may treat patients with different levels of
21 complexity, and who may require different treatments. Notably this includes addiction medicine
22 physicians who may prescribe medications for opioid use disorder (MOUD) at higher rates than
23 other specialists; pain medicine, oncologists, hospice or palliative care physicians who may
24 prescribe opioids at higher rates than other specialists; or psychiatrists who may prescribe
25 benzodiazepines or stimulants at higher rates than other specialists.

26
27 In addition to the physicians who face an investigation that yields no charges—or when a
28 physician’s office is closed temporarily or a conviction leads to permanent closure—there is always
29 massive disruption to the practice and patients. For example, if a physician’s DEA registration is
30 suspended, every patient receiving controlled substances still requires a physician’s care.³⁴ And if a
31 pharmacy no longer is authorized to dispense buprenorphine, for example, in a rural area, hundreds
32 of patients will be affected.³⁵ To try and help mitigate the harms associated with the sudden closure
33 of a clinic or pharmacy, the U.S. Centers for Disease Control and Prevention (CDC) operate the
34 “Opioid Rapid Response Program” (ORRP) to help mitigate patient harm and work with state
35 health officials when physicians are no longer authorized to provide care due a law enforcement or
36 similar action against them.³⁶ The ORRP has worked in 40 states since 2021 and “received over
37 240 notifications from federal law enforcement about potential disruptions to healthcare for
38 patients receiving controlled substance medications.” Finally, the Association of State and
39 Territorial Health Officials published a 2021 guide that provides further information for states.³⁷

40 41 AMA POLICY

42
43 The AMA broadly recognizes that the nation’s overdose epidemic is complicated. (H-95.981,
44 Federal Drug Policy in the United States) AMA policy addresses the need for protections for
45 patients with pain (D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids) as
46 well as for individuals with an opioid use disorder. (D-95.972, Expanding Access to Buprenorphine
47 for the Treatment of Opioid Use Disorder) AMA policy also emphasizes the need for balance by
48 the DEA to support patients with pain while taking steps to reduce misuse and diversion of
49 controlled substances. (D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled
50 Substances) AMA policy also highlights the need for working with law enforcement on educational
51 outreach with respect to “appropriate” prescribing practices, as well as efforts to help prevent

1 misuse and diversion. (H-95.990, Drug Abuse Related to Prescribing Practices) Finally, the AMA
2 does not have specific policy on what constitutes a “legitimate medical purpose,” although AMA
3 policy strongly supports state regulation of the practice of medicine. (H-275.978, Medical
4 Licensure)

5
6 CONCLUSION

7
8 The AMA cannot prevent physicians from being investigated by law enforcement. Violations of
9 the CSA for prescribing medication without a legitimate medical purpose, outside the usual course
10 of professional practice, are not to be tolerated because such violations do not represent the practice
11 of medicine. However, the AMA also does not support investigations that serve as so-called fishing
12 expeditions that ensnare physicians—often those who provide care to the most vulnerable
13 patients—in years of emotional, financial, and professional turmoil. The Board does not believe
14 that law enforcement regularly engages in wanton or specious activities against physicians, but we
15 do believe that increased guidance for law enforcement and physicians is warranted. Specifically,
16 the Board recommends that federal law enforcement activities use state medical practice acts as
17 their guide as to what is a “legitimate medical purpose.” Every state defines the practice of
18 medicine with greater clarity than federal regulations or statute. If a federal law enforcement
19 agency seeks to investigate a physician in a particular state, the Board recommends that law
20 enforcement start with understanding how a state defines the practice of medicine. This is not
21 meant to hinder appropriate investigations, but to help guide law enforcement and physicians alike.
22

23 The Board, therefore, recommends that the HOD adopt new policy that advocates for the
24 U.S. Department of Justice (DOJ) to rely on state medical board definitions of “the practice of
25 medicine” to guide investigations into whether a practitioner has acted without a “legitimate
26 medical purpose.” The Board also recommends that the HOD adopt policy directing the AMA and
27 its interested medical association partners to work more closely with the DOJ to clearly identify the
28 factors that the DOJ uses during an investigation. The Board further recommends that the HOD
29 adopt policy directing the AMA to support the CDC’s Opioid Rapid Response Program and similar
30 state-based efforts to reduce disruptions to care caused by law enforcement or other actions.
31

32 RECOMMENDATIONS

33
34 The Board of Trustees recommends the following be adopted and the remainder of the report be
35 filed.
36

- 37 1. That the referred clause from Resolution 209-A-25, “Reducing Risk of Federal Investigation or
38 Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes,” not be
39 adopted.
40
- 41 2. That our American Medical Association advocate to the U.S. Department of Justice to rely on
42 state medical board definitions of “the practice of medicine” to guide investigations into
43 whether a practitioner has acted without a legitimate medical purpose. (Directive to Take
44 Action)
45
- 46 3. That our AMA advocate to the U.S. Department of Justice to work more closely with the AMA
47 and its interested medical association partners to more clearly identify the factors it uses during
48 an investigation to minimize disruptions to patient care. (Directive to Take Action)
49
- 50 4. That our AMA support the U.S. Centers for Disease Control and Prevention Opioid Rapid
51 Response Program and similar state-based efforts that seek to ensure continuity of care when

- 1 patients lose access to care due to a law enforcement or other action that results in the closure
- 2 of a physician's practice. (New AMA Policy)

Fiscal Note: Less than \$500.

APPENDIX A



Practice of Medicine – Location Defined

Summary

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

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
AL		X	Medical Practice Act Ala. Code 34-24-50, et. Seq. “Practice of medicine or osteopathy” defined. “The ‘practice of medicine or osteopathy’ means: (1) To diagnose, treat, correct, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain, or other condition, physical or mental, real or imaginary, by any means or instrumentality; (2) To maintain an office or place of business for the purpose of doing acts described in subdivision (1), whether for compensation or not...”
AK			2011 Alaska Statutes Title 08. BUSINESS AND PROFESSIONS Chapter 08.64. MEDICNE Sec. 08.64.380. Definitions. “(5) ‘practice of medicine’ or ‘practice of osteopathy’ means: (a) For a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;”
AZ		X	Arizona Title 31 – Professions and Occupations, Chapter 13 – Medicine and Surgery, Article 1 – Arizona Medical Board 32-1401 Definitions. “‘Practice of medicine’ means the diagnosis, the treatment or the correction of or the attempt or claim to be able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities or deformities, physical or mental, real or imaginary, by any means, methods, devices or instrumentalities, except as the same may be among the acts or persons not affected by this chapter. The practice

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			of medicine includes the practice of medicine alone or the practice of surgery alone, or both.”
AR			<p>Arkansas Medical Practices Act and Regulations. Sub-Chapter 2-General Provisions. 17.95.202. Definitions.</p> <p>(3) “Practice of medicine’ means:</p> <p>(a) Holding out one’s self to the public within this state as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever,</p> <p>(b) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly or indirectly, any fee, gift, or compensation whatsoever;</p> <p>(c) Maintaining an office or other place to meet persons for the purpose of examining or treating person afflicted with disease, injury, or defect of body or mind;</p> <p>(d) Using the title “M.D.”, “M.B.”, “D.O.”, “physician”, “surgeon”, or any other word or abbreviation to indicate or induce others to believe that one is engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind, except as otherwise expressly permitted by the laws of this state relating to the practice of any limited field of the healing arts;</p> <p>(e) Performing any kind of surgical operation upon a human being; or</p> <p>(f) Delegating certain medical practices to other personnel under rules adopted by the board</p> <p>(g)</p>
CA			
CO	X	X	<p>The Colorado Medical Board Policies, 40-27, page 101. Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine. 8/19/21.</p> <p>“Providers who evaluate, treat or prescribe through telehealth technologies are practicing medicine. The practice of medicine occurs where the patient is located at the time telehealth technologies are used.”</p>
CT		X	
DE	X	X	<p>2021 Delaware Code Title 24 – Professions and Occupations Chapter 17. Medical Practice Act Subchapter I. General Provisions Sect 1702. Definitions.</p> <p>“For the purposes of this chapter, in order that the full resources of the State are available for the protection of persons using the services of physicians, the act of the practice of medicine occurs where a person is located at the time a physician practices medicine upon the person.”</p>
DC		X	<p>3 DMCR § 1201.02. Definitions of health occupations.</p> <p>(7)(A) “Practice of medicine” means suggesting, recommending, prescribing, or administering, with or without compensation, any form of treatment, operation,</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			<p>drug, medicine, manipulation, electricity, or any physical, mechanical, or healing treatment by other means, for the prevention, diagnosis, correction, or treatment of a physical or mental disease, ailment, injury, condition, or defect of any person, including:</p> <ul style="list-style-type: none"> (i) The management of pregnancy and parturition; (ii) The interpretation of tests, including primary diagnosis of pathology specimens, images, or photographs; (iii) Offering or performing a surgical operation upon another person; (iv) Offering or performing any type of invasive procedure of the body, whether through a body opening or a cutting of the skin, or otherwise affecting the layer of skin below the stratum corneum, for surgical, therapeutic, or cosmetic purposes, excluding procedures known as body tattooing or body piercing; (v) Rendering a written or otherwise documented medical opinion relating to the diagnosis and treatment of a person within the District, or the actual rendering of treatment to a person within the District, by a physician located outside the District as a result of transmission of the person’s medical data by electronic or other means from within the District to the physician or to the physician’s agent; (vi) Maintaining an office or other place for the purpose of examining persons afflicted with disease, injury, or defect of body or mind; (vii) Advertising or representing in any manner that one is authorized to practice medicine; or (viii) Using the designation “Doctor of Medicine,” “Doctor of Osteopathy,” “physician,” “surgeon,” “physician and surgeon,” “M.D.,” or “D.O.,” or a similar designation, or any combination thereof, in the conduct of an occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of another branch of the healing arts for which one holds a valid license.
FL			<p>Title XXXII Regulation of Professions and Occupations, Chapter 458 Medical Practice, 458.305 Definitions “‘Practice of medicine’ means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition.”</p>
GA		X	<p>2020 Georgia Code Title 43 – Professions and Businesses Chapter 34 – Physicians, Acupuncture, Physician Assistants, Cancer and Glaucoma Treatment, Respiratory Care, Clinical Perfusions, and Orthotics and Prosthetics Practice Article 2 – Medical Practice Sect 43-34-21. Definitions “‘To practice medicine,’ ‘the practice of medicine,’ or ‘practice medicine’ means to hold oneself out to the public as being engaged in the diagnosis or treatment of disease, defects, or injuries of human beings; or the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or the maintenance of an office for the reception, examination, and treatment of persons suffering from disease, defect, or injury of body or mind;...”</p>
GU		X	<p>10 GCA Health and Safety. Ch. 12 Medical Practices</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			<p>(b) The Healing Art means the art of prevention, detecting or attempting to detect the presence of any disease; of determining or attempting to determine the nature and state of any disease, if present; or preventing, relieving, correcting or curing of or attempting to prevent, relieve, correct or cure any disease; of safeguarding or attempting to safeguard the life of any woman or infant through pregnancy and parturition; and of doing or attempting to do any of the acts enumerated in this Subsection. The healing arts include, but are not limited to, optometry, nursing, chiropractic, dentistry, medicine and surgery, physician assistants, podiatry, psychology, osteopathic, pharmacy, physical therapy, acupuncture, speech language pathology, audiology, respiratory therapy, nutritionist/clinical dietician, cosmetology and veterinary medicine.</p> <p>(c) To Practice means to do or attempt to do, or to hold oneself out or to allow oneself to be held out as ready to do, any act enumerated in Subsection(b) of this Section as constituting a part of the healing art for a fee, gift, reward or in anticipation of any fee, gift or reward whether tangible or intangible.</p>
HI			<p>Hawaii Revised Statues 453-1-Practice of medicine defined “... the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines; surgery; manual medicine; water; electricity; hypnotism; telehealth; the interpretation of tests, including primary diagnosis of pathology specimens, medical imaging, or any physical; osteopathic medicine; any means, method, or agent, either tangible or intangible, to diagnose, treat, prescribe for, palliate, or correct disease, or prevent any human disease, condition, ailment, pain, injury, deformity, illness, infirmity, defect, physical or mental condition in the human subject.”</p>
ID		X	<p>Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1803. Definitions. “‘Practice of medicine’ means:</p> <ul style="list-style-type: none"> (a) The investigation, diagnosis, treatment, correction, or prevention of or prescription for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality that involves the application of principles or techniques of medical science; or (b) Offering, undertaking, or holding oneself out as able to do any of the acts described in paragraph (a) of this subsection.” <p>Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1844. Definitions. “‘Practice of medicine’ means the clinical prevention, diagnosis or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the medical practice act of a member state”</p>
IL		X	<p>225 ILCS 60/49.5. From ch. 111, par 4400-38 (e) An out-of-state person providing a service listed in Section 49 to a patient residing in Illinois through the practice of telemedicine submits himself or herself to the jurisdiction of the courts of this State.</p>
IN		X	<p>IC 25-22.5-1-1.1 Definitions. “(a) ‘practice of medicine or osteopathic medicine’ means any one (1) or a combination of the following</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			<p>2) The maintenance of an office or a place of business for the reception, examination, or treatment of persons suffering from disease, ailment, defect, injury, infirmity, deformity, pain, or other conditions of body or mind.</p> <p>4) Providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services:</p> <p>A) are transmitted through electronic communications; and</p> <p>B) are on a regular, routine, and nonepisodic basis or under an oral or written agreement to regularly provide medical services.</p> <p>In addition to the exceptions described of section 2 of this chapter, a nonresident physician who is located outside Indiana does not practice medicine or osteopathy in Indiana by providing a second opinion to a licensee or diagnostic or treatment services to a patient in Indiana following medical care originally provided to a patient while outside Indiana.</p>
IA		X	<p>Chapter 148 Medicine and Surgery and Osteopathic Medicine and Surgery. 148.1 Persons engaged in practice.</p> <p>148.1 Persons engaged in practice. For the purpose of this subtitle, the following classes of persons shall be deemed to be engaged in the practice of medicine and surgery or osteopathic medicine and surgery: 1. Persons who publicly profess to be physicians and surgeons or osteopathic physicians and surgeons, or who publicly profess to assume the duties incident to the practice of medicine and surgery or osteopathic medicine and surgery. 2. Persons who prescribe, or prescribe and furnish, medicine for human ailments or treat the same by surgery</p>
KS		X	<p>Healing Arts Act 65-2802. 65-2869. Persons deemed engaged in practice of medicine and surgery.</p> <p>a. Persons who publicly profess to be physicians or surgeons, or publicly profess to assume the duties incident to the practice of medicine or surgery or any of their branches.</p> <p>b. Persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder, of human beings.</p>
KY		X	<p>311.500 Definitions for KRS 311.530 to 311.620 and 311.990(4) to (6)</p> <p>Except as provided in subsection (11) of this section, the ‘practice of medicine or osteopathy’ means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;</p>
LA		X	<p>2011 Louisiana Laws Revised Statutes TITLE 37 – Professions and occupations RS 37:1262 – Definitions.</p> <p>“The practice of medicine,” whether allopathic or osteopathic, means the holding out of one’s self to the public as being engaged in the business of, or the actual engagement in, the diagnosing, treating, curing, or relieving of any bodily or mental disease, condition, infirmity, deformity, defect, ailment, or injury in any human being, other than himself, whether by the use of any drug, instrument or force, whether physical or psychic, or of what other nature, or any other agency or means; or the examining, either gratuitously or for compensation, of any person or material from any person for such purpose whether such drug, instrument, force, or other agency or means is applied to or used by the patient or by another person; or the attending of a woman in childbirth without the aid of a licensed physician or midwife.</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
ME		X	<p>2021 Maine Revised Statutes: Title 32: Processions and Occupations. Chapter 48: Board of Licensure in Medicine. Subchapter 3: General Provisions. Sect. 3300-D. Interstate practice of telemedicine.</p> <p>5. Jurisdiction. In registering to provide interstate telehealth services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State.</p>
MD		X	<p>Statutes Article – Health Occupations Sect. 14-101</p> <p>(O) (1) “Practice medicine” means to engage, with or without compensation, in medical:</p> <ul style="list-style-type: none"> (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery. <p>2) “Practice medicine” includes doing, undertaking, professing to do, and attempting any of the following:</p> <ul style="list-style-type: none"> (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: <ul style="list-style-type: none"> 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. By appliance, test, operation, or treatment; (ii) Ending of a human pregnancy; and (iii) Performing acupuncture as provided under sec. 14-504 of this title.
MA			<p>243 CMR: Board of Registration In Medicine. 243 CMR 2.00: Licensing and the Practice of Medicine. 2.01: Scope and Construction</p> <p>The Practice of Medicine means the following conduct, the purpose or reasonably foreseeable effect of which is to encourage the reliance of another person upon an individual's knowledge or skill in the maintenance of human health by the prevention, alleviation, or cure of disease, and involving or reasonably thought to involve an assumption of responsibility for the other person's physical or mental well being: diagnosis, treatment, use of instruments or other devices, or the prescribing, administering, dispensing or distributing of drugs for the relief of diseases or adverse physical or mental conditions.</p> <p>(a) A person who holds himself or herself out to the public as a physician or surgeon, or with the initials "M.D." or "D.O." in connection with his or her name, and who also assumes responsibility for another person's physical or mental well being, is engaged in the practice of medicine</p> <p>(b) The Practice of Medicine includes the following:</p> <ul style="list-style-type: none"> 1. Telemedicine, as defined in 243 CMR 2.01: Telemedicine; and 2. Providing an independent medical examination or a disability evaluation.
MI		X	<p>Mich. Comp. Laws § 333.17001 Definitions; principles of construction.</p> <p>(j) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.</p>
MN		X	<p>147.081 PRACTICING WITHOUT LICENSE; PENALTY. Subd. 3.Practice of medicine defined.</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			<p>For purposes of this chapter, a person not exempted under section 147.09 is "practicing medicine" or engaged in the "practice of medicine" if the person does any of the following:</p> <ol style="list-style-type: none"> (1) advertises, holds out to the public, or represents in any manner that the person is authorized to practice medicine in this state; (2) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another; (3) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person; (4) offers or undertakes to perform any surgical operation including any invasive or noninvasive procedures involving the use of a laser or laser assisted device, upon any person; or (5) offers to undertake to use hypnosis for the treatment or relief of any wound, fracture, or bodily injury, infirmity, or disease.
MS	X	X	<p>MS Admin. Code Title 30, Part 2635, Rule 5.2. “The practice of medicine is deemed to occur in the location of the patient.”</p>
MO			<p>Title XII Public Health and Welfare. Chapter 191. 191.1145. Definitions 3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.</p>
MP			<p>Title 185: Commonwealth Health Care Professions Licensing Board. Chapter 185-10 Commonwealth Health Care Professions Licensing Board Regulations. Part 4200 – Physician – Doctor of Osteopathy. Sect 185-10-4201 Definitions (dd) “Practice of Medicine” means:</p> <ol style="list-style-type: none"> (1) Holding out one’s self to the public as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever; (2) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly or indirectly, any fee, gift or compensation whatsoever; (3) The maintenance of an office or other place to meet persons for the purpose of examining or treating persons afflicted with disease, injury, or clinical defect of the body or mind; (4) Using the title “Doctor,” “Doctor of Medicine,” “Doctor of Osteopathy,” “Physician,” “Surgeon,” “Dr.,” “M.D.,” “D.O.,” or any word or abbreviation to indicate or induce others to believe that one is engaged in the practice of medicine defined herein; (5) Performing any kind or surgical operation upon a human being.
MT		X	<p>Montana Code 2021 Title 37 Professions and Occupations Chapter 3. Medicine Part 1. General Definitions 31-3-102 “Practice of medicine” means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.
NC			<p>Chapter 90 Medicine and Allied Occupations. Article 1. Practice of Medicine. Sect 90-1.1. Definitions.</p> <p>The practice of medicine or surgery. - Except as otherwise provided by this subdivision, the practice of medicine or surgery, for purposes of this Article, includes any of the following acts:</p> <ol style="list-style-type: none"> a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State. b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual. c. Offering or undertaking to prevent or diagnose, correct, prescribe for, administer to, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition. d. Offering or undertaking to perform any surgical procedure on any individual. f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone.
ND		X	<p>Chapter 43-17 Physicians and Surgeons. 43-17-01. Definitions.</p> <p>5. "Practice of medicine" includes the practice of medicine, surgery, and obstetrics. The following persons are regarded as practicing medicine:</p> <ol style="list-style-type: none"> a. A person that holds out to the public as being engaged within this state in the diagnosis or treatment of diseases or injuries of human beings. b. A person that suggests, recommends, or prescribes any form of treatment for the intended relief or cure of any physical or mental ailment of any individual, with the intention of receiving, directly or indirectly, any fee, gift, or compensation. c. A person that maintains an office for the examination or treatment of individuals afflicted with disease or injury of the body or mind.
NE		X	<p>Nebraska Revised Statute 38-2024 Practice of Medicine and Surgery, defined.</p> <p>Persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state.</p>
NH		X	<p>Title XXX Occupations and Professions. Chapter 329 Physicians and Surgeons. Section 329:1-d Telemedicine.</p> <p>II. An out-of-state physician providing services by means of telemedicine shall be deemed to be in the practice of medicine and shall be required to be licensed under this chapter.</p>
NJ		X	<p>NJ State Board of Medical Examiners Law. Article 1 Practice of Medicine and Surgery in General. 45:9-5.1. Definitions.</p>

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			"the practice of medicine or surgery" and the phrase "the practice of medicine and surgery" shall include the practice of any branch of medicine and/or surgery, and any method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition
NM			<p>NM Statutes Annotated. Sec. 61-6-6(K). "The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state, to the physician or the physician's agent, OR the rendering of treatment to a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician's agent."</p>
NV		X	<p>NRS 630.020 "Practice of medicine" defined. "Practice of medicine" means: 1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy. 2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions. 3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics, including, without limitation, through telehealth, from within or outside this State or the United States.</p> <p>NRS 629.515 Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient, the provider must hold a valid license or certificate to practice his or her profession in this State</p>
NY			<p>NY Education Law Article 131, Medicine. Sect 6521. Definition of practice of medicine. The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.</p>
OH		X	<p>State medical Board of Ohio Position Statement on Telemedicine The "practice of telemedicine" is defined in Ohio as the practice of medicine in this state through the use of any communication, including oral, written or electronic communication, by a physician located outside this state.</p>
OK		X	<p>Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act. Tite 59 O.S., Sect. 492. Practice of Medicine and Surgery – Title - Hospital C. The definition of the practice of medicine and surgery shall include, but is not limited to: b. Except as provided in subsection D of this section, performance by a person within or outside of this state, through an ongoing regular arrangement, of diagnostic or treatment services, including but not limited to, stroke prevention</p>

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			and treatment, through electronic communications for any patient whose condition is being diagnosed or treated within this state. A person who performs any of the functions covered by this subparagraph submits himself or herself to the jurisdiction of the courts of this state for the purposes of any cause of action resulting from the functions performed.
OR			<p>Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.085 What constitutes practice of medicine. A person is practicing medicine if the person does one or more of the following: (1) Advertise, hold out to the public or represent in any manner that the person is authorized to practice medicine in this state. (2) For compensation directly or indirectly received or to be received, offer or undertake to prescribe, give or administer any drug or medicine for the use of any other person. (3) Offer or undertake to perform any surgical operation upon any person. (4) Offer or undertake to diagnose, cure or treat in any manner, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person. (5) Except as provided in ORS 677.060, append the letters “M.D.” or “D.O.” to the name of the person, or use the words “Doctor,” “Physician,” “Surgeon,” or any abbreviation or combination thereof, or any letters or words of similar import in connection with the name of the person, or any trade name in which the person is interested, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions mentioned in this section.</p> <p>Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.135 “Practice of medicine across state lines” defined (1) The rendering directly to a person of a written or otherwise documented medical opinion concerning the diagnosis or treatment of that person located within this state for the purpose of patient care by a physician or physician assistant located outside this state as a result of the transmission of individual patient data by electronic or other means from within this state to that physician, the physician’s agent or a physician assistant; or (2) The rendering of medical treatment directly to a person located within this state by a physician or a physician assistant located outside this state as a result of the outward transmission of individual patient data by electronic or other means from within this state to that physician, the physician’s agent or a physician assistant.</p>
PA		X	
PR			
RI		X	<p>Licensure and Discipline of Physicians (216-RICR-40-05-1) 1.2 Definitions. "Practice of medicine" means the practice of allopathic and osteopathic medicine. Any person shall be regarded as practicing medicine within the meaning of the Act who holds himself or herself out as being able to diagnose, treat, perform surgery, use a laser/intense pulsed light, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal</p>

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			physical or mental condition, or who shall either profess to heal, offer or undertake, by any means or method, to diagnose, treat, perform surgery, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition. In addition, one who attaches the title M.D., physician, surgeon, D.O., osteopathic physician and surgeon, or any other similar word or words or abbreviation to his or her name indicating that he or she is engaged in the treatment or diagnosis of the diseases, injuries or conditions of persons shall be held to be engaged in the practice of medicine. Non-ablative treatment is part of the practice of medicine.
SC			<p>Title 40 – Professions and Occupations Chapter 47 Physicians and Miscellaneous Health Care Professionals. Article 1 General Provisions. Section 40-47-10. 36.</p> <p>“Practice of Medicine” means:</p> <ul style="list-style-type: none"> (a) Advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in this State; (b) Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person; (c) Offering or undertaking to prevent or to diagnose, correct or treat in any manner, or by any means, methods, or devices, disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of a person, including the management of pregnancy and parturition; (d) Offering or undertaking to perform any surgical operation upon a person; (e) Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within this State by a physician located outside the state as a result of individual patient data by electronic or other means from within a state to such physician or his agent
SD		X	<p>Chapter 36-2 Practitioners of Healing Arts in General. 36-2-1. Definition of terms.</p> <p>"Healing art," "healing," "art of healing," "practicing healing," "practicing of healing," any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, unhealthy or abnormal physical or mental condition;</p>
TN		X	<p>2010 Tennessee Code Title 63 – Professions of the Healing Arts. Chapter 6 – Medicine and Surgery. Part 2 – General Provisions. 63-6-204 – Practice of medicine defined.</p> <ul style="list-style-type: none"> (a) (1) Any person shall be regarded as practicing medicine, within the meaning of this chapter, who treats, or professes to diagnose, treat, operates on or prescribes for any physical ailment or any physical injury to or deformity of another.
TX		X	<p>Occupations Code. Title 3. Health Professions. Subtitle B. Physicians. Chapter 151. General Provisions. Subchapter A. General Provisions. Sec. 151.002. Definitions.</p>

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

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

Last Updated: September 2022

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

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- ¹ 21 U.S.C. § 801 et seq.
- ² Practitioner’s Manual. United States Department of Justice. Drug Enforcement Administration. Diversion Control Division. Revised 2023. Available at [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-071\)\(EO-DEA226\)_Practitioner's_Manual_\(final\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-071)(EO-DEA226)_Practitioner's_Manual_(final).pdf)
- ³ 21 CFR § 1306.04 - Purpose of issue of prescription.
- ⁴ See, for example, 21 CFR § 1300.03 - Definitions relating to electronic orders for controlled substances and electronic prescriptions for controlled substances; 21 CFR § 1304.45 - Internet Web site disclosure requirements; 21 CFR § 1307.41 - Temporary extension of certain COVID-19 telemedicine flexibilities for prescription of controlled medications.
- ⁵ 21 CFR 1300.02
- ⁶ 21 CFR 1306.04
- ⁷ 90 FR 9243
- ⁸ 87 FR 30276
- ⁹ 88 FR 75309
- ¹⁰ Practitioner’s Manual. United States Department of Justice. Drug Enforcement Administration. Diversion Control Division. Revised 2023. Available at [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-071\)\(EO-DEA226\)_Practitioner's_Manual_\(final\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-071)(EO-DEA226)_Practitioner's_Manual_(final).pdf)
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- ¹³ *Akhtar-Zaidi v. DEA*, 841 F.3d 707, 710 (6th Cir. 2016)
- ¹⁴ *Ruan v. United States*, 597 U.S. 450, 142 S. Ct. 2370, 213 L. Ed. 2d 706 (2022)
- ¹⁵ *United States of America, v. Jeffrey H. Feingold*, 454 F.3d 1001 (9th Cir. 2006)
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REPORT OF THE BOARD OF TRUSTEES

BOT Report 14-A-26

Subject: Binding Arbitration in Health Insurance Contracts (Resolution 208-A-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

4
5 That our American Medical Association will study the effects of binding arbitration in
6 health insurance contracts with physicians.

7
8 Testimony received by the HOD regarding Policy D-435-967 expressed concerns that binding
9 arbitration clauses in health insurance contracts limit physicians’ legal recourse, reduce
10 transparency, and can disproportionately favor insurers.

11 DISCUSSION

12 *General Differences Between Binding Arbitration and Litigation*

13
14 Binding arbitration is an alternative to litigation as a means of resolving disputes. Arbitration
15 agreements are typically included in participation agreements between physicians and health
16 insurers. Arbitration agreements usually state that proceedings will be conducted according to
17 rules adopted by the American Arbitration Association, the American Health Law Association, or
18 JAMS.
19
20

21
22 Arbitration is less formal than litigation, and the specific procedures of any given arbitration
23 proceeding can vary widely based on the choices the parties make in their arbitration agreement.
24 Arbitration agreements often forgo the application of the formal rules of civil procedure,
25 discovery, and the admissibility of evidence that would otherwise apply in litigation.
26

27 Court proceedings are generally open to the public and court filings are usually publicly
28 available. Arbitrations are typically private, where the parties agree to keep the proceedings and
29 arbitration award confidential.
30

31 Court cases are often assigned at random to generalist judges, but in arbitration the parties may
32 have a direct role in choosing the arbitrator who will adjudicate the dispute. Parties are often able
33 to select experienced arbitrators with specialized knowledge.
34

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

1 *Commonly Discussed Pros and Cons of Arbitration*

2
3 The effects of binding arbitration in physician contracts with health insurers can be studied by
4 examining the commonly discussed pros and cons of arbitration vis-à-vis litigation.

5
6 Potential Advantages of Arbitration

7
8 Arbitration may have several advantages when compared with litigation. However, some
9 advantages may not be fully realized when the parties to arbitration agreements differ
10 significantly in bargaining power, which can be the case when physicians and health insurers are
11 the negotiating parties. Unequal bargaining power may enable health insurers to impose on
12 physicians mandatory binding arbitration agreements that favor insurers.

13
14 As noted above, arbitration proceedings are usually less formal and complex than those involved
15 in litigation, which can make arbitration less expensive and a faster way to resolve disputes. For
16 example, physicians and health insurers may agree to limit discovery, e.g., restrict the number of
17 depositions, interrogatories, document requests, etc. Arbitration may also settle disputes more
18 efficiently because physicians and health insurers may be able to schedule hearings more quickly
19 than in judicial proceedings, where a judge must fit hearing dates in among many other cases.

20
21 Another advantage frequently cited is the ability to retain arbitrators with specialized knowledge.
22 If the dispute between a physician practice and a health insurer concerns reimbursement, the
23 parties may be able to select an arbitrator who is familiar with coding, payment rules, fee
24 schedules, etc., about which a judge may know very little. In such cases, the arbitrator's expertise
25 could result in a fairer, timelier, and less costly resolution because the parties will not need to
26 educate a judge and jury about the technical aspects of disputes that frequently occur between
27 physicians and health insurers.

28
29 The finality of the arbitrator's decision may make arbitration cheaper and more efficient than
30 judicial proceedings. Only in very limited circumstances may a party disagreeing with an
31 arbitrator's decision appeal that decision to a court. Consequently, parties do not spend money or
32 prolong the dispute process by subsequent appeals that are available in litigation.

33
34 Potential Disadvantages of Arbitration

35
36 Arbitration may not always be less expensive than litigation. Filing fees can be much higher than
37 they are in judicial proceedings. Unlike judges, arbitrators charge hourly fees for their services,
38 and it is not unusual for arbitration agreements between physicians and health insurers to call for
39 three arbitrators to hear disputes above a specific threshold, e.g., \$2,000,000. Thus, arbitrator fees
40 can end up being quite costly. And physicians still must pay for attorneys just as they would in
41 litigation.

42
43 The limited ability to appeal an arbitration decision is a potential drawback of arbitration just as it
44 may potentially be advantageous, since a physician will not be able to have a court review an
45 adverse arbitration decision.

46
47 Confidentiality may have its advantages, but it also may give rise to a lack of transparency that
48 can be disadvantageous. If arbitration decisions are confidential, a physician will not be able to
49 find out how an arbitrator has ruled in past disputes, e.g., whether the arbitrator has a reputation
50 for competency and fairness. Not having this kind of information can make it more difficult for a
51 physician to request, from his or her perspective, the best arbitrator to hear any given dispute.

1 Finally, in cases where a health insurer may have significantly more bargaining power than the
2 physician, the arbitration agreement may require the physician to waive rights that would apply
3 in litigation or otherwise agree to unfavorable terms. For example, the arbitration agreement may
4 restrict the statute of limitations within which the physician must file a dispute, limit the damages
5 that an arbitrator may award, waive pre-judgment interest, waive the right to join with other
6 physicians to resolve similar disputes, including but not limited to class actions or class
7 arbitrations. The arbitration agreement may require the physician to arbitrate the dispute in
8 person at a location, e.g., the health insurer's offices, which may not be convenient. The
9 agreement may state that the party losing the arbitration must pay the winner's costs, and it is
10 highly likely that a physician cannot risk incurring such costs to the extent a health insurer can.
11

12 *The Federal Arbitration Act and State Arbitration Laws*

13
14 Enacting legislation is the obvious strategy to address unfavorable aspects of binding arbitration
15 agreements. State legislatures and state courts have attempted to place conditions on binding
16 arbitration clauses to deal with situations where one party to the agreement may have more
17 bargaining power than the other party. Such efforts are, however, usually preempted by the
18 Federal Arbitration Act (FAA).
19

20 Congress passed the FAA in 1925 to ensure that arbitration agreements were enforced, in part to
21 address growing concerns about the costliness and delays of litigation. Section 2 of the FAA
22 states in part that:
23

24 [a] written provision in any maritime transaction or a contract evidencing a transaction
25 involving commerce to settle by arbitration a controversy thereafter arising out of such
26 contract or transaction...shall be valid, irrevocable, and enforceable, save upon such
27 grounds as exist at law or in equity for the revocation of any contract.
28

29 According to the U.S. Supreme Court (Court), in enacting Section 2 of the FAA Congress
30 "declared a national policy favoring arbitration and withdrew the power of the states to require a
31 judicial forum for the resolution of claims which the contracting parties agreed to resolve by
32 arbitration."¹ The Court has also determined that the FAA preempts state laws that treat
33 arbitration agreements differently than other contracts. So, state laws that "single out" arbitration
34 agreements for special treatment are preempted by the FAA. Based on these and other
35 pronouncements, courts regularly rule that the FAA preempts state laws that interfere with, or
36 place conditions on, arbitration agreements.
37

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

1 disfavoring contracts that (oh so coincidentally) have the defining features of arbitration
2 agreements.”³

3
4 Thus, as things stand today, a state legislative strategy to place conditions on arbitration
5 agreements between physicians and health insurers is not likely to be successful unless the FAA
6 is significantly amended.

7
8 *Amending the Federal Arbitration Act*

9
10 The FAA would have to be amended so that conditions or restrictions could be placed on binding
11 arbitration agreements between physicians and health insurers. Since its enactment over one
12 hundred years ago, Congress has made only a few, very specific, amendments to the FAA.⁴ Bills
13 introduced in Congress proposing to make more significant changes to the FAA have not been
14 successful. Presently, it is unlikely that Congress will make the kinds of changes to the FAA
15 necessary to alter the current status of binding arbitration agreements between physicians and
16 health insurers.

17
18 *The AMA Should Provide Resources to Physicians*

19
20 The Board of Trustees fully understands that unequal bargaining power between a health insurer
21 and a physician may result in a physician being bound by an arbitration agreement that
22 disproportionally favors the insurer, and that physicians need assistance. Even though a
23 legislative approach to addressing concerns that physicians can have about binding arbitration is
24 not likely to succeed at this time, the AMA can create resources to support physicians who are
25 being asked to sign binding arbitration agreements. These resources could help physicians
26 understand the possible advantages and disadvantages of binding arbitration and the extent to
27 which those advantages and disadvantages are reflected in arbitration agreements offered to
28 them. This information will be designed to help physicians negotiate more favorable arbitration
29 agreements when they have the power to do so. But even if physicians cannot negotiate,
30 resources will help physicians evaluate the arbitration agreements offered to them so that they
31 can fully understand how to exercise the rights they do possess.

32
33 CONCLUSION

34
35 The Board, therefore, recommends that the HOD modify policy D-435.967, “Binding Arbitration
36 in Health Insurance Contracts” by adding a new directive to D-435.967 requiring that our AMA
37 create resources to help physicians evaluate binding arbitration agreements with health insurers
38 so that physicians can identify the advantages and disadvantages that may be present in those
39 agreements. The Board also recommends modifying D-435.967 by rescinding language calling
40 on the American Medical Association to study the effects of binding arbitration in health
41 insurance contracts with physicians, since this report constitutes the required study.

1 RECOMMENDATION

2
3 The Board of Trustees recommends that the following be adopted, and the remainder of the
4 report be filed:

- 5
6 1. That our American Medical Association Policy D-435.967, “Binding Arbitration in Health
7 Insurance Contracts,” be rescinded having been accomplished by this report. (Rescind HOD
8 Policy)
- 9 2. That our AMA create resources to help physicians evaluate binding arbitration agreements
10 with health insurers so that physicians can identify the advantages and disadvantages that
11 may be present in those agreements. Resources shall include, but not be limited to: (1)
12 developing model arbitration language that protects physicians when such clauses are used;
13 (2) establishing fairness principles or standards for arbitration provisions in physician-insurer
14 contracts; (3) identifying specific contract red flags such as venue restrictions that physicians
15 should be aware of when reviewing arbitration clauses; and (4) encouraging greater
16 transparency or reporting around arbitration outcomes. (New HOD Policy)
- 17 3. That our AMA (1) opposes requiring mandatory binding arbitration as a condition of
18 participation in an insurance company’s provider network; (2) supports a physician’s right to
19 choose between arbitration and the public court system after a dispute arises, rather than
20 being forced to waive their right to a jury trial; (3) believes that no physician should be
21 required to participate in an arbitration or mediation process that is not the result of
22 meaningful mutual agreement between the physician and health insurer; (4) advocates that all
23 arbitration awards involving physician-payer disputes be reported to a centralized de-
24 identified database to ensure transparency and to identify patterns of frequent bad-faith
25 claims settlement practices by insurers. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ *Southland Corp. v. Keating*, 465 U.S. 1, 10 (1984)

² *Kindred Nursing Centers Limited Partnership v. Clark*, 581 U.S. 246, 250 (2017)

³ *Id* at 251

⁴ A recent example was the 2022 enactment of the Ending Forced Arbitration of Sexual Assault and Sexual Harassment Act (Act) which was first introduced in 2017. The Act prohibits employers from requiring employees or contractors to arbitrate sexual assault or sexual harassment claims.

REPORT 15 OF THE BOARD OF TRUSTEES (A-26)
Protecting the Prescriptive Authority of Plenary Licensed Physicians
Reference Committee B

EXECUTIVE SUMMARY

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 204-A-25, “Protecting the Prescriptive Authority of Plenary Licensed Physicians,” was adopted. This resolution resulted in Policy D-120.920, “Preserving Patients' Ability to Have Legally Valid Prescriptions Filled,” which directed the AMA to study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.”

This report provides background on legal and clinical requirements for valid prescriptions, examines the shared responsibilities of physicians and pharmacists, provides available data and related information, and outlines relevant AMA policy.

While pharmacists play an essential role on physician-led care teams, particularly in ensuring medication safety, concerns arise when pharmacists refuse to dispense prescriptions based on judgments outside their education and training. Such refusals can contribute to patient harm, including uncontrolled symptoms, relapses or debilitation, and additional harm. At the same time, this report affirms the pharmacist’s legal and ethical obligations and their “corresponding responsibility” to verify prescription validity, including resolving technical errors and addressing safety concerns or so-called “red flags.”

This report also highlights how corporate policies and pharmacy benefit management company requirements can also compel pharmacists to refuse to fill legitimate prescriptions, effectively overriding individual professional judgment.

Finally, this report emphasizes the need for improved communication between physicians and pharmacists and renewed engagement with national pharmacy organizations. This report highlights that existing AMA policy strongly supports physician-led teams, recognizes the important role of pharmacists, and opposes inappropriate pharmacy intrusion into medical practice.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-A-26

Subject: Protecting the Prescriptive Authority of Plenary Licensed Physicians

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

- 6
7 1. Our AMA will study the national prevalence and patterns of pharmacists refusing to fill
8 valid prescriptions from plenary licensed physicians, including impact on patient
9 outcomes and prescriber autonomy.

10
11 Testimony universally acknowledged that pharmacists play an important role as part of a
12 physician-led team. Testimony further highlighted physicians’ appreciation for their pharmacy
13 colleagues to assist with medication safety. Questions and concerns arise, however, when
14 pharmacists make determinations that go beyond their education and training, including making
15 decisions to withhold medication from patients after it has been prescribed by a physician for a
16 legitimate medical purpose in the usual course of professional practice. This report studies the
17 national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary
18 licensed physicians, including impact on patient outcomes and prescriber autonomy. It provides
19 relevant background, discusses issues raised by the resolution, cites AMA policy, and makes
20 recommendations.

21 22 BACKGROUND

23
24 In determining whether a prescription is “valid,” there are multiple technical, clinical, and legal
25 considerations that must be considered. These technical and legal considerations, which may vary
26 slightly by state, generally require the physician to include multiple elements on the prescription,
27 including:

- 28
29 • Name, address, phone number of the prescribing physician;
30 • Full name and address of the patient (also known as the “ultimate user”);
31 • The drug name and strength;
32 • Specific directions for use, including number of times per day and number of days total;
33 • Quantity of the drug to be dispensed;
34 • Number of refills authorized by the prescriber;
35 • Whether the prescriber allows for substitutions, including generic versions, or whether
36 the prescription shall be dispensed as written;
37 • The prescriber’s signature, which may be required to be manually written, or for
38 electronic prescriptions, additional requirements that help protect against fraud or
39 forgery;

- 1 • Other information, such as diagnostic codes, may be required by a state;¹
- 2 • Prescriptions for controlled substances have additional requirements, including the
- 3 prescriber’s DEA number;² and
- 4 • Electronic prescriptions for controlled substances also have additional requirements.³

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

13
14 In terms of the “clinical” or additional legal considerations for what constitutes a valid
15 prescription, general guidance comes from the Controlled Substances Act (CSA). The CSA,
16 which the Board of Trustees (the Board) acknowledges only technically applies to controlled
17 substances, provides guidance that:

18
19 A prescription for a controlled substance to be effective must be issued for a
20 legitimate medical purpose by an individual practitioner acting in the usual
21 course of his professional practice. The responsibility for the proper prescribing
22 and dispensing of controlled substances is upon the prescribing practitioner, but
23 a corresponding responsibility rests with the pharmacist who fills the
24 prescription. An order purporting to be a prescription issued not in the usual
25 course of professional treatment or in legitimate and authorized research is not a
26 prescription within the meaning and intent of section 309 of the Act (21 U.S.C.
27 829) and the person knowingly filling such a purported prescription, as well as
28 the person issuing it, shall be subject to the penalties provided for violations of
29 the provisions of law relating to controlled substances.

30
31 For the purposes of this report, the Board considers an “effective prescription” to carry
32 equivalent weight and meaning as when discussing a “valid prescription.” The CSA makes clear
33 that there are mutual, complementary roles for the physician and the pharmacist. While the
34 physician carries the primary responsibility for ensuring a prescription’s validity, the pharmacist
35 has a corresponding responsibility to ensure the prescription’s validity. In fulfilling the
36 corresponding responsibility, as physicians commonly experience, the pharmacist may ask
37 questions of the patient and the physician to help ensure the medication prescribed meets the
38 necessary safety requirements per the pharmacist’s education and training. Per the CSA, the
39 ultimate decision whether to fill and dispense a prescription, rests with the pharmacist.

40 41 DISCUSSION

42
43 The AMA believes that all qualified health care professionals play an integral role in the delivery
44 of health care in the United States. Efficient delivery of care requires a team-based approach,
45 which cannot exist without inter-professional collaboration between physicians, pharmacists,
46 nurses, and other health care professionals. When each member of the health care team plays his
47 or her optimal and unique role—a role that should be clearly defined by one’s education and
48 training, the AMA believes patients reap the benefits. The AMA defines “physician-led” in the
49 context of team-based health care as the consistent use by a physician of the leadership
50 knowledge, skills and expertise necessary to identify, engage and elicit from each team member

1 the unique set of training, experience, and qualifications needed to help patients achieve their
2 care goals, and to supervise the application of these skills.⁶

3
4 *Potential Conflicts that Arise*

5
6 If a pharmacist does not believe that a prescription presented by a patient or a patient surrogate
7 has all the required technical information, the pharmacist has a professional and legal
8 responsibility to not fill or dispense that prescription until the legal requirements are met.
9 Similarly, if a pharmacist has cause to question other aspects about a prescription, the pharmacist
10 generally has a legal and ethical obligation to resolve questions before filling or dispensing the
11 prescription. There also are legal obligations put upon pharmacists who are employed by
12 pharmacies subject to the national, multistate opioid litigation settlement agreements for
13 pharmacists to resolve so-called “red flags.”⁷ Pharmacists who fill or dispense invalid
14 prescriptions, or those for which all “red flags” have not been resolved, bear the professional and
15 legal penalties that result. Despite this pressure, the Board continues to encourage cordial,
16 professional interactions between physicians and pharmacists to resolve any outstanding
17 questions and to help ensure the physician-pharmacist-patient therapeutic triad works for the
18 benefit of patients’ health and safety.⁸

19
20 The Board acknowledges that conflicts may arise, however, when a pharmacist determines that it
21 is not within a physician’s scope of practice to treat a particular medical condition. The AMA is
22 aware of many examples of this happening across different medical specialties, including
23 ophthalmology, dermatology, oncology, physiatry, hospice and palliative medicine, addiction
24 medicine, obstetrics and gynecology, and surgery, to name a few. While the Board will not go
25 into the unique circumstances of each situation, the Board remains steadfast in its support of
26 patients retaining the ability to have legitimate prescriptions filled and dispensed. The AMA
27 opposes pharmacists deciding on their own, to invalidate a prescription solely because of a
28 determination that it is outside the prescribing physician’s scope of practice. The AMA also
29 opposes actions by corporations to issue corporate blocks on physicians without due process or
30 an understanding of the unique situation/circumstances of the physician’s practice.⁹

31
32 When a pharmacist refuses to fill a legitimate prescription issued in the usual course of
33 professional practice, there is the potential for multiple negative outcomes. For a patient with an
34 irritating skin condition, for example, the result could be worsening of symptoms and an
35 increased chance of debilitation. For a patient with opioid use disorder (OUD), the result could
36 be relapse and return to use of illegally made fentanyl or other substances.¹⁰ For a patient with
37 cancer or chronic pain, the result could be increased suffering and seeking out illicit, toxic forms
38 of pain relief.^{11,12} These are but a few examples where a pharmacist’s refusal could lead to
39 unnecessary pain and suffering.

40
41 At the same time, if a pharmacist identifies a potential drug safety issue, the outreach to the
42 prescribing physician can be the difference between life and death. The Board does not want to
43 put a chill into the pharmacist’s essential role to help ensure drug safety and education by
44 suggesting—let alone demanding—that a pharmacist fill and dispense any prescription
45 transmitted by a physician. In such cases where a medication dosage was inadvertently
46 transcribed as 100mg 2x/day instead of 10mg 2x/day, for example, ensuring the correct dose is
47 essential. Physicians value pharmacists acting as a secondary check for technical errors, typos or
48 potentially harmful drug-drug interactions. A resilient, productive relationship with pharmacists
49 should be thought of as a key component of the “Swiss cheese model” of adverse event
50 prevention.¹³ This might also include automated pharmacy system alerts when certain
51 medications are prescribed or ordered for concurrent administration.

1 Similarly, if a pharmacist contacts the physician to alert the physician that the patient has
 2 multiple prescriptions for the same medication from different prescribers, the Board sees this as
 3 an opportunity to improve continuity of care and support patient safety. Even though the Board
 4 opposes inappropriate pharmacy intrusions into the practice of medicine, we also know that
 5 beneficial physician-pharmacist communication occurs on a regular basis. Moreover, if a
 6 pharmacist determines—based on the pharmacist’s education and training, combined with
 7 additional information from the prescriber and patient—that the prescription is not for a
 8 legitimate medical purpose issued in the usual course of professional practice, the Board
 9 acknowledges that the pharmacist may legally refuse to dispense that medication.

10
 11 Satisfactorily determining legitimacy of the prescription from the pharmacist’s point of view
 12 raises other issues, as well. As noted above, communicating with prescribers can be essential in
 13 ascertaining the legitimacy of a controlled substance prescription, although simply phoning a
 14 prescriber and inquiring if the prescription is legitimate may not be satisfactory. In the case of
 15 prescribers who may be involved in illicit prescribing practices, for example, it is highly unlikely
 16 that the response to an inquiry from the pharmacist concerning the legitimacy of the prescription
 17 would be for the prescriber to affirm that the prescription is not legitimate. This is clearly
 18 different from a situation where, for example, pharmacists refuse to fill and dispense a
 19 prescription for an eye rash because they believe only dermatologists are trained to know when it
 20 is safe to prescribe a cream for an eye rash.

21
 22 A different issue arises, however, when the pharmacist’s own professional judgment is
 23 effectively made null and void by an employer’s policy. This may occur when a payor, pharmacy
 24 corporation, or pharmacy benefit manager impose policies that either directly or effectively force
 25 the pharmacist to refuse to fill and dispense a prescription. This is common for opioid
 26 prescriptions or treatment of OUD but also arises with stimulants and other controlled
 27 substances. In many cases, the corporate entity has essentially told their state-licensed
 28 pharmacists that any prescriptions written by specific health care professionals shall not be filled
 29 under any circumstance. The AMA would like to believe that a pharmacist’s professional and
 30 ethical obligations would rise past the boundaries of a corporate edict, but we believe that it must
 31 be acknowledged that that has not been the case in far too many situations. While these situations
 32 are not those that gave rise to the underpinnings of this report, the Board would be remiss to
 33 ignore the conflicts that pharmacists often face.

34
 35 *National Prevalence and Patterns of Pharmacists Refusing to Fill Valid Prescriptions*

36
 37 How often does a pharmacist’s inquiry about a patient’s prescription or decision to reject a
 38 physician’s prescription occur? Data regarding national prevalence or patterns is sparse, but there
 39 are a limited number of studies providing at least some insight. In one study,¹⁴ researchers found
 40 that pharmacists were willing to refuse to dispense prescriptions that were deemed unsafe, even if
 41 they contacted the prescriber. The same study found that in other situations, even if the
 42 prescription was deemed unsafe, 75 percent of pharmacists responding said that they filled the
 43 prescription because they “felt the prescriber knew the medical history or clinical situation better
 44 than they did.” The study also presented respondents with five hypothetical medication scenarios
 45 to test pharmacists’ decision-making. The researchers concluded that, “Pharmacists appeared
 46 more aligned with a patient counseling and prescriber consulting role than with withholding
 47 likely dangerous prescriptions which have been verified by the prescriber.”

48
 49 There also is limited data with respect to specific medical conditions. A 2022 American Society
 50 of Addiction Medicine study, for example, found that 45 percent of respondents said that a
 51 “pharmacy or pharmacist declined to fill the prescription for buprenorphine.”¹⁵ Among the

1 reasons given for the denial: (1) concern that the prescription was clinically inappropriate; (2)
 2 corporate policy limiting or prohibiting dispensing of medication; or (3) belief that the Drug
 3 Enforcement Administration (DEA) has a cap on the quantity of buprenorphine that can be
 4 dispensed. While most patients were able to ultimately have their prescription filled at a different
 5 pharmacy, 14 percent could not get their prescription filled. The outcome for those patients is
 6 unclear.

7
 8 This issue has been particularly nettlesome with respect to filling and dispensing prescriptions for
 9 opioid analgesics. The Board will not delve too deeply into this issue as it has been covered many
 10 times before, but for the purposes of this report, there are several relevant points that we would
 11 like to make. First, as detailed above, there are studies showing that patients with cancer and/or
 12 chronic pain have been denied access to the medication recommended by their physician. Even
 13 Walmart, which operates more than 5,000 pharmacies¹⁶ at its Walmart and Sam’s Club locations,
 14 acknowledges that complaints have been filed against it for refusing to dispense medication in
 15 40 states.¹⁷ Further, a small Texas study found that, “Patients with cancer perceived difficulties
 16 when filling their opioid prescriptions, and the results suggest that negative interactions with the
 17 pharmacy and/or pharmacist contribute to their perceived difficulty.”¹⁸

18
 19 While these studies show that inappropriate actions by pharmacists do occur, the limited number
 20 makes it challenging to identify specific patterns or national prevalence of such actions. There is
 21 certainly anecdotal information concerning refusals to fill medications for pain or OUD because
 22 of a physician’s scope of practice—and the AMA has been clear in its opposition, including
 23 drafting model state legislation to help prevent corporate pharmacy interference in the practice of
 24 medicine. The AMA has shared this model state legislation with multiple medical societies, and
 25 the AMA Advocacy Resource Center is available to support any state interested in pursuing such
 26 legislation.

27
 28 To effectively identify national patterns and prevalence, however, we believe that we need more
 29 than anecdotes or secret shopper surveys. At a minimum, we need specific data sources of
 30 refusals, and reasons for such refusals. One place where such data might exist is from the parties
 31 subject to the national opioid litigation settlement agreement.¹⁹ Provisions within the agreement
 32 require pharmacies, wholesalers, and distributors to create processes to monitor such occurrences
 33 and document actions when a prescription is “rejected pursuant to Red Flags identified by the
 34 pharmacist.”²⁰ It is not clear, however, whether this data is publicly accessible. The Board
 35 believes that a review of such data would help illuminate the issues raised by the resolution and
 36 identified in this report.

37
 38 A brief review of prominent data sources highlights other challenges with identifying relevant
 39 data. Prescription drug monitoring programs (PDMPs) are a comprehensive source of data for the
 40 prescribing and dispensing of controlled substances, but they only contain information about
 41 prescriptions dispensed. Specifically, they do not capture data on prescriptions refused.
 42 Electronic health records also would have information about patients’ prescription history, but it
 43 is not likely such history includes refusals to fill. This is to say that while the Board agrees that
 44 knowing national patterns and prevalence of pharmacists refusing to fill valid prescriptions could
 45 provide actionable insight, the challenges in creating such a data set and performing the
 46 necessary retrospective analysis would be considerable. The Board, therefore, recommends that
 47 the AMA Advocacy team continue to strongly support physician-led teams, work with national
 48 pharmacy organizations in support of those teams, and encourage physicians and pharmacists to
 49 rely on each other’s unique education and training to the benefit of their patients.

1 The Board also notes the related, but distinct issue of pharmacist refusals to dispense valid
2 prescriptions based on personal belief. Reports of refusals to dispense contraception, emergency
3 contraception, abortifacients, or other reproductive health medications have surfaced in at least
4 26 states, indicating that the issue is geographically widespread.²¹ Survey data also suggest that
5 conscience-based refusals, while not predominant, are not negligible. In one survey of
6 community pharmacists conducted in 2010, nearly six percent indicated they would refuse to
7 dispense and decline to transfer at least one controversial medication, including emergency
8 contraception or abortifacients.²² These refusals can delay or foreclose timely access to
9 prescribed care, particularly in rural or underserved areas where alternative pharmacies may not
10 be readily available.

11
12 Additionally, conscience refusals have been bolstered in recent years by a growing number of
13 state legislatures that have enacted statutory “conscience clause” protections allowing
14 pharmacists and other healthcare professionals to decline to provide certain healthcare services
15 on moral or religious grounds.

16 17 AMA POLICY

18
19 AMA policy supports developing and building strong relationships with our pharmacy colleagues
20 while simultaneously “protect[ing] patients’ ability to have valid prescriptions filled.”
21 (D-120.975, “Preserving Patients’ Ability to Have Legally Valid Prescriptions Filled”). AMA
22 policy also guides the AMA in efforts at the state and federal levels “to protect the authority of
23 plenary licensed physicians to prescribe all legal medications in accordance with their training
24 and medical judgment.” (D-120.920, “Protecting the Prescriptive Authority of Plenary Licensed
25 Physicians”). AMA policy further “opposes pharmacists being given the authority to initiate or
26 modify prescription drug treatment except on a case-by-case basis at the specific direction of a
27 physician.” (H-160.928, “Drug Initiation or Modification by Pharmacists”).

28
29 AMA policy recognizes “the contribution of pharmacy as an independent profession in assisting
30 physicians toward the constant goal of improved patient care is recognized and commended.”
31 (H-35.999, “Medicine and Pharmacy Relations”). The AMA “urges physicians to encourage and
32 support the continued growth of pharmacy as a valuable and necessary member of the health
33 team. (H-35.999, “Medicine and Pharmacy Relations”). AMA policy strongly supports a
34 physician-led health care team that includes pharmacists for their role in support of preventing
35 medication errors (H-120.965, “Medication Errors”), as well as for consultations with patients.
36 (H-120.932, “Pharmacy Review of First Dose Medication”).

37
38 Finally, while the AMA strongly supports pharmacists playing an integral role as part of a
39 physician-led health care team, AMA policy “deems inappropriate inquiries from pharmacies to
40 verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an
41 interference with the practice of medicine and unwarranted. (H-35.961, “AMA Response to
42 Pharmacy Intrusion into Medical Practice”).

43 44 CONCLUSION

45
46 Refusing to fill a valid prescription issued in the usual course of professional practice for a
47 legitimate medical purpose risks patient harm. If a pharmacist has a question to help ensure the
48 accuracy and safety of a prescription, it is important for pharmacists to feel confident in reaching
49 out to the prescribing physician. This does not mean, however, that pharmacists should seek
50 information that is beyond their education and training. Nor does it mean that pharmacists have a
51 right to refuse to fill and dispense a prescription solely because pharmacists do not agree that a

1 physician’s specialty matches what the pharmacist expects for a given prescription. Physician-
2 pharmacist conflicts are rare, but the Board understands that they occur—and that it is incumbent
3 upon all of us to work together for our patients’ health and safety.
4

5 Given the high degree of interprofessional respect that occurs daily between physicians and
6 pharmacists—combined with the clarity of AMA policy that simultaneously highlights the
7 benefits of pharmacists on the health care team while opposing interference in medical practice—
8 the Board does not believe that additional policy is required. Rather, the Board supports renewed
9 efforts to proactively engage with our pharmacy colleagues to explore additional avenues in
10 which the issues raised in this report might be addressed in a collaborative fashion between the
11 two professions.
12

13 The Board, therefore, recommends that the HOD adopt new policy that focuses on convening
14 national pharmacy organizations to identify solutions to address the issues raised in this report
15 and to urge pharmacies subject to the national opioid litigation settlements to provide data on
16 refusals to fill and dispense medications, including the reasons for such refusals. The Board also
17 recommends the HOD reaffirm of Policy H-120.947, “Preserving Patients’ Ability to Have
18 Legally Valid Prescriptions Filled” as it is directly on point in terms of the issues raised by this
19 report. Finally, the Board recommends that the HOD rescind the first item of Policy
20 D-120.920 as this report has accomplished the directive to study the national prevalence and
21 patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians,
22 including impact on patient outcomes and prescriber autonomy.
23

24 RECOMMENDATIONS

25

26 The Board of Trustees recommends that the following be adopted, and the remainder of the
27 report be filed.
28

- 29 1. That our American Medical Association convene a meeting with the National
30 Association of Boards of Pharmacy and other national pharmacy organizations to
31 identify ways to improve communications between physicians and pharmacists about
32 physicians’ and pharmacists’ corresponding responsibility and related areas. (Directive to
33 Take Action)
34
- 35 2. That our AMA urge pharmacies subject to the national opioid litigation settlements to
36 provide data on refusals to fill and dispense medications, including the reasons for such
37 refusals. (Directive to Take Action).
38
- 39 3. That our AMA Policy H-120.947, “Preserving Patients’ Ability to Have Legally Valid
40 Prescriptions Filled,” be reaffirmed. (Reaffirm HOD Policy)
41
- 42 4. That Policy D-120.920 “Preserving Patients’ Ability to Have Legally Valid Prescriptions
43 Filled,” be amended by deletion of the first item to read as follows:
44
 - 45 ~~1. Our American Medical Association will study the national prevalence and patterns of~~
46 ~~pharmacists refusing to fill valid prescriptions from plenary licensed physicians,~~
47 ~~including impact on patient outcomes and prescriber autonomy.~~
48 1.1. Our AMA will work with state medical boards, pharmacy boards, and appropriate
49 federal agencies to protect the authority of plenary licensed physicians to prescribe
50 all legal medications in accordance with their training and medical judgment.

- 1 3.2. Our AMA will reaffirm and publicize existing policy opposing unauthorized
2 medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment
3 modification by pharmacists.
4 4.3. Our AMA supports legislation or regulatory action requiring pharmacists and
5 pharmacy chains to either fill a valid prescription or immediately refer the patient to
6 an alternative dispensing pharmacy, with notification to the prescribing physician.
7 5.4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice
8 boundaries, educate interested parties on the legal authority of plenary licensure, and
9 promote policies that ensure timely patient access to physician led care. (Modify
10 Current HOD Policy)

Fiscal note: Less than \$500.

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² 21 CFR § 1306.04. Purpose of issue of prescription.
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⁴ 42 CFR § 455.440. National Provider Identifier.
⁵ National Provider Identifier Standard (NPI). Centers for Medicaid and Medicare Services. September 10, 2024. <https://www.cms.gov/regulations-and-guidance/administrative-simplification/nationalprovidentstand>
⁶ AMA Policy H-160.906. Models/Guidelines for Medical Health Care Teams.
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⁹ AMA letter to Reginald Dilliard, PhD, Executive Director, Tennessee Board of Pharmacy. May 13, 2021. Available at <https://searchf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/2021-5-13-Letter-to-TN-Board-of-Pharmacy-FINAL.pdf>
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¹⁶ Careers. Walmart. <https://careers.walmart.com/us/en/home/careers-areas/healthcare/pharmacy>

¹⁷ Correcting the Record on Opioid Lawsuits Against Walmart. Walmart. Sep. 6, 2022. <https://corporate.walmart.com/news/2022/09/06/correcting-the-record-on-opioid-lawsuits-against-walmart>

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²⁰ Walgreens Settlement Agreement. Section VIII. The Prescription Validation Process.

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²² Davidson, et al., Religion and conscientious objection: a survey of pharmacists' willingness to dispense medications, 71 Soc Sci Med 1, 161-5 (Jul. 2010)

REPORT 19 OF THE BOARD OF TRUSTEES (A-26)
Root Cause Analysis of the Causes of the Decline of Private Medical Practice

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, [Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice”](#) was adopted by the House of Delegates (HOD). This policy directs the American Medical Association (AMA) to study and report back on the root cause of the decline in private practice (including but not limited to: the declining inflation-adjusted Medicare rates, Stark laws, the permitted consolidation of insurers and hospitals, hospital-insurer agreements that are minimal for physicians who are in-network compared with out-of-network, increased government influence by insurers and hospitals and decreased influence by doctors, inadequate formal education on the business of medicine, educational debt of early career physicians, evolving lifestyle preference of early career physicians, overhead expenditures, and hospital-based facility fees). This report examines contributing factors in the decline of private practice—organized into four categories: economic pressures, market consolidation, administrative and regulatory burden, and generational workforce factors.

Economic pressures were divided into two categories: (1) those that reduce practice revenue such as declining inflation-adjusted Medicare reimbursement and (2) those that increase practice costs such as overhead expenditures (e.g., EHRs, personnel, and administrative costs). The report highlights how consolidation among hospitals and commercial insurers affects the sustainability of independent physician-owned practices, including hospital-insurer agreements with minimal in-network fee requirements, conditions such as high hospital technical fees, and insurance plans without out-of-network benefits. The report notes that, as consolidation increases, resulting shifts in alignment and influence may further dilute the voice of physicians in private practice.

The report further examines how increased market consolidation can amplify the disproportionate impact of administrative and regulatory burdens on smaller and independent practices, as physicians in larger systems may have dedicated compliance infrastructure to manage these requirements (e.g., EHR interoperability, value-based payment reporting, and billing code changes). Additionally, it addresses generational workforce factors contributing to the decline of private practice, such as increasing retirement rates of “baby-boomer” physicians, younger physicians’ lifestyle preferences and stronger focus on work-life balance, personal financial considerations, and limited business education. Finally, an analysis is provided of how several of these factors dynamically interact, contributing to a reinforcing feedback loop.

In addition to categorizing and analyzing factors driving the decline of private medical practice, this report also lists relevant AMA efforts including Medicare payment reform advocacy, educational resources and programs, research, and policy.

Given the AMA’s substantial efforts in advocating for and developing resources concerning the preservation of private medical practice, the AMA recommends that (1) several existing policies be reaffirmed (Reaffirm HOD Policy), (2) the AMA identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions (New HOD Policy), (3) Policy D-405.965 be rescinded (Rescind HOD Policy), and (4) the remainder of the report be filed.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 19-A-26

Subject: Root Cause Analysis of the Causes of the Decline of Private Medical Practice

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

1 At the 2025 Annual Meeting, [Policy D-405.965, “Root Cause Analysis of the Causes of the](#)
2 [Decline of Private Medical Practice,”](#) was adopted by the House of Delegates (HOD). This policy
3 directs the American Medical Association (AMA) to do the following:
4

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

- 7 1. The declining inflation-adjusted Medicare rates.
- 8 2. Stark laws, which allow hospitals, but not private physicians, to self-refer.
- 9 3. The development of insurance plans that had no out-of-network benefits.
- 10 4. The permitted consolidation of insurers and hospitals.
- 11 5. Hospital-insurer agreements with minimal in-network fee requirement and other
12 conditions such as the requirement for high hospital technical fees.
- 13 6. Increased government influence by insurers and hospitals and decreased influence by
14 doctors.
- 15 7. Inadequate formal education on the business of medicine.
- 16 8. Educational debt of early career physicians.
- 17 9. Evolving lifestyle preference of early career physicians.
- 18 10. Overhead expenditures such as Electronic Health Records (EHRs), personnel, and
19 administrative costs.
- 20 11. Provider based facility fees charged by hospital employers but not by private
21 practitioners.
22

23 This report includes detailed information about the root causes of the decline of private medical
24 practice, organizing contributing factors into four categories—economic pressures, market
25 consolidation, administrative and regulatory burden, and generational workforce factors—to better
26 contextualize and understand their interaction. It also highlights the AMA’s efforts to address these
27 issues and recommends strengthened communication and engagement so that available AMA
28 resources and solutions more effectively reach physicians in private practice and those considering
29 transitioning to private practice.
30

31 BACKGROUND

32
33 Private practice can be defined as a medical practice wholly owned by one or more physicians.
34 There has been an overall decline in physician ownership of medical practices over the past four
35 decades, dropping especially precipitously from 61 percent physician owners in 2008 to 35.4
36 percent in 2024. Similarly, the proportion of physicians working in private practice as employees
37 or owners has fallen from 60.1 percent in 2012 to 42.2 percent in 2024, as described in the AMA
38 Physician Practice Benchmark Surveys.¹

1 Private practice was a cornerstone of American medicine in the 20th century, representing a distinct
 2 health care delivery model with specific advantages and disadvantages. Despite evidence that
 3 suggests physician-owned practices are slower to adopt innovations such as health information
 4 technology² and care management processes³, they are equivalent or better than other models of
 5 practice in total spending and quality measures such as preventable hospital admissions,
 6 readmissions, and emergency department visits.⁴ Additionally, the autonomy associated with being
 7 a practice owner may contribute to physician well-being.⁵

9 The U.S. health care system overall has undergone significant change in the last several decades,
 10 including rising health care costs, continued downward pressure on payment, wide adoption of
 11 EHRs and other technology, the rise of chronic disease burden and more complex care, and more
 12 recently, the downstream effects of a global pandemic. During this period, many private practices
 13 have been acquired by hospitals and health systems. Drivers of this shift were recorded by the 2022
 14 AMA Physician Practice Benchmark Survey, where 80 percent of physicians whose practices were
 15 acquired indicated that the need to better negotiate favorable (higher) payment rates with payers
 16 was a very important (46.1 percent) or important (33.4 percent) reason as to why their practice was
 17 sold to or acquired by a hospital or health system. The need to better manage payers' regulatory
 18 and administrative requirements and improve access to costly resources were both reported by
 19 approximately 70 percent of physicians as a very important or important reason for selling their
 20 practice.⁶

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

27 **DISCUSSION**

29 For the purpose of this discussion, a basic root cause analysis fishbone diagram⁷ was used to
 30 categorize the delineated factors in Policy D-405.965 into overarching themes. This diagram can be
 31 viewed in the appendix section at the end of this report (Figure 1). Although other potential factors
 32 were not included in the analysis, this categorical framework can be used to include other causes in
 33 the future.

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

39 *Economic Pressures*

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

1 Declining Inflation-Adjusted Medicare Rates

2
3 Adjusted for inflation in practice costs, Medicare physician payment declined 33 percent from
4 2001 to 2026.⁸ Furthermore, reimbursement systems for commercial health insurance plans tend to
5 be based upon the Medicare system, albeit generally at higher rates. While the decline in these rates
6 affect physicians in all practice settings, it may disproportionately affect those in private practice
7 given that a larger percentage of revenue may be generated through the fee-for-service payments
8 driven by the Medicare Physician Fee Schedule (MPFS).

9
10 Overhead Expenditures such as EHRs, Personnel, and Administrative Costs

11
12 During the same time period from 2001 to 2026, practice expenditures rose by 63 percent, with
13 rapid acceleration beginning in 2021.⁸ In addition to inflationary pressures on rents, personnel, and
14 supplies, medical practices were also subject to increased costs associated with the acquisition of
15 technology (e.g., EHRs to fulfill meaningful-use requirements, telehealth during the Covid-19
16 pandemic, digital systems to fulfill quality reporting requirements).⁹ These practice costs can
17 potentially be mitigated through economies of scale, which small private practices may not have.

18
19 Provider-Based Facility Fees Charged by Hospital Employers but not by Private Practitioners

20
21 Under the standard reimbursement system for traditional fee-for-service Medicare, in addition to
22 physician payment through the MPFS “facility” rates, hospital outpatient departments (HOPDs)
23 (with some exclusions) receive payment for ambulatory services under the OPFS. Clinicians
24 rendering services in freestanding physician-owned offices receive payment through the MPFS
25 “non-facility” rates, and the private practices do not receive payment through OPFS. This is the so-
26 called “site-of-service differential.” For example, in 2023, an initial preventative exam was
27 reimbursed at a 51 percent higher rate in an existing HOPD than in a freestanding physician-owned
28 office.¹⁰ Another study addressing the commercial insurance market in 2022 found that on average,
29 total payment for an ambulatory service in a HOPD was 145 percent more than in a physician
30 office.¹¹ The “site-of-service differential” can advantage hospital-based outpatient services
31 compared to those in free-standing physician offices.

32
33 Additionally, current implementation of the 340B Drug Pricing Program has been criticized for
34 advantaging hospitals because it allows them to buy drugs at discounted rates while receiving full
35 reimbursement—creating revenue streams unavailable to many private practice physicians—
36 contributing to hospital acquisition of physician practices and care consolidation.¹² This has
37 especially impacted private practice physicians in the oncology, rheumatology, and
38 gastroenterology specialties.^{13,14} The program has also been critiqued for incentivizing hospitals to
39 shift care from underserved areas to wealthier communities to increase revenue.¹² AMA [Policy H-
40 110.985, "340B Drug Discount Program"](#) recognizes that the 340B program does not support the
41 extent of care provided by ineligible physician practices to the medically indigent or underserved,
42 and commits to working with HRSA to establish 340B eligibility for all practices demonstrating a
43 commitment to serving low-income and underserved patients.

44
45 Market Consolidation

46
47 Horizontal consolidation pertains to the situation when organizations in a common market,
48 delivering the same services, combine. For example, this happens when two hospitals in the same
49 city merge, or when one large health insurer buys out a smaller insurer that covers the same

1 population. This type of consolidation decreases competition and leads to the increased pricing
2 power of the dominant entities.

3
4 Vertical consolidation happens when organizations in a common market, contributing different
5 services along the delivery chain, combine. The classic example is a health system buying one or
6 more physician practices. While this type of integration may have benefits in streamlining care
7 coordination, there may also be the downside consequence of decreasing competition. Both
8 situations can adversely affect the financial sustainability of physicians in private practice as their
9 market power diminishes.

10 11 The Permitted Consolidation of Insurers and Hospitals

12
13 There has been continued consolidation in the health care market as it pertains to both hospitals and
14 commercial insurers. For instance in 2023, one or two health systems controlled the entire market
15 for inpatient hospital care in almost half of metropolitan statistical areas (MSAs), and nearly all (97
16 percent) had highly concentrated markets for inpatient hospital care.¹⁵ Similarly, the insurers are
17 also consolidating, leading to a highly concentrated health insurance market. A recent study from
18 the AMA reveals that 97 percent of MSA-level commercial markets in 2023 were highly
19 concentrated according to the Herfindal-Hirschman Indices (HHI) and Department of Justice
20 (DOJ)/Federal Trade Commission (FTC) merger guidelines.¹⁶

21
22 There are many detrimental effects of health care consolidation on the sustainability of smaller
23 independent physician-owned practices. In highly concentrated markets, small independent
24 practices do not have much leverage in negotiations of reimbursement rates from commercial
25 payers. Smaller independent practices may also have a difficult time negotiating competitive
26 pricing for resources and human capital if located in a market with a dominant hospital/health
27 system with similar needs. Smaller practices are also disproportionately impacted when payors or
28 hospitals/health systems enter exclusivity contracts. In a consolidated market, practices excluded
29 from these agreements lose access to most patients and are unable to survive. These effects are
30 further magnified when payors or health systems directly or indirectly employ physicians.

31 32 Hospital-Insurer Agreements with Minimal In-Network Fee Requirement and Other Conditions 33 Such as the Requirement for High Hospital Technical Fees

34
35 Given the market leverage that dominant health systems possess, they can negotiate terms with
36 commercial payers which allow them to gain advantage. The so-called “anti-steering clause” (or
37 “anti-incentive clause”) is a requirement that the insurer places the health system at the lowest cost-
38 sharing rate to avoid steering patients away from the health system’s network. Other contract
39 clauses which insurers and some hospital systems can employ to gain advantage are the
40 following¹⁷:

- 41
- 42 • Most Favored Nation (MFN) Clause
- 43 • Non-compete Clause
- 44 • All-or-nothing Clause
- 45 • Anti-tiering/Anti-steering Clause
- 46 • Gag Clause (Price Secrecy Provision)
- 47 • Exclusive Contracting Clause¹⁷
- 48

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

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

2
3 Traditionally, preferred provider organization (PPO) and point of service health plans have out-of-
4 network benefits, while health maintenance organization (HMO) and exclusive provider
5 organization (EPO) plans do not. While all these health plan types have existed for decades, the
6 relative adoption of these plans has changed with time. PPO plans remain common in employer-
7 sponsored plans. However, the individual marketplace has shifted dramatically in favor of HMO
8 and EPO plans, with some states having no PPO plans in the marketplace.¹⁸ Given the transition to
9 these options, the negotiating power of dominant health systems to include all-or-nothing clauses in
10 their payer contracts can amplify exclusion of private practices in payer networks.

11
12 Increased Government Influence by Insurers and Hospitals and Decreased Influence by Doctors

13
14 As health care markets continue to consolidate, it follows that these larger entities may exert
15 increased influence on local, state and federal governments, both directly and through affiliated
16 societies and umbrella organizations. Physicians continue to have a strong voice through organized
17 medicine. However, as ever more complex organizations are formed, there are new shifts in
18 alignment and influence that may dilute the voice of physicians in private practice.

19
20 *Administrative & Regulatory Burdens*

21
22 Burdens related to compliance are felt by physicians in all practice settings. However, physicians
23 affiliated with larger systems may be more sheltered from these burdens as they may have
24 dedicated compliance infrastructures in place. Furthermore, additional regulations regarding
25 physician ownership, including Stark and anti-kickback laws, may disadvantage physicians in
26 private practice.

27
28 The Physician Self-Referral (Stark) Law

29
30 In [Policy D-385.940, “Stark Law Self-Referral Ban”](#), the AMA recognizes the challenges the Stark
31 law may pose to many physician practices and that restrictions on self-referral may be a
32 contributing factor to market consolidation. However, the Stark law does not provide a blanket ban
33 on self-referral practices. Rather, it contains numerous exceptions, which if met, allow physicians
34 to self-refer (e.g., when physicians self-refer to risk bearing arrangements). Most importantly for
35 the purposes of this report, the Stark law has a broad exception for both ownership interests and
36 compensation arrangements that applies specifically to physician practices—the in-office ancillary
37 services exception. That said, the increased costs of legal and administrative work required to form
38 and maintain the structures necessary to comply with these Stark law exceptions may be
39 significant.

40
41 Administrative Burdens

42
43 Private practice physicians face substantial administrative and regulatory burdens, often exceeding
44 those experienced by physicians employed by larger systems with dedicated compliance
45 infrastructure. These burdens include requirements for quality reporting, prior authorizations, payer
46 contracting and credentialing, regulatory compliance for privacy and security (e.g., HIPAA), and
47 maintenance of licensure and certification.

48
49 The cumulative time devoted to administrative tasks not directly related to patient care has been a
50 major contributor to physician dissatisfaction and burnout.¹⁹ In smaller practices, physicians often
51 personally handle or oversee these requirements, whereas larger organizations are able to delegate

1 to specialized administrative personnel. The increasing complexity of federal, state, and payer
2 requirements—especially regarding EHR interoperability, value-based payment reporting²⁰, and
3 frequent changes to billing codes—has raised the cost of compliance and further strained private
4 practice viability.

5 6 *Generational Workforce Factors*

7
8 As the “baby-boom” generation continues to age out of the physician workforce, factors affecting
9 the younger generations, including lifestyle preferences, personal finances, and lack of business
10 education, may contribute significantly to decreasing numbers of graduating trainees and early
11 career physicians choosing to enter private practice. Trainees’ limited exposure to the professional
12 satisfaction associated with private practice may also lead them to select other models of practice.

13 14 Inadequate Formal Education on Business Skills

15
16 In 2023, the AMA conducted a study investigating physician career transitions in which 35
17 physicians who changed jobs between health care organization employment, private practice, or
18 non-clinical roles were interviewed. Although the main objective of this research was to identify
19 drivers of these transitions, the potential avenues of support for the physician career journey were
20 also studied. One of the key unmet needs that these physicians identified was that “physicians
21 across experience levels benefit from exposure to business and other skills.” These skills are not
22 typically taught in medical education and training due to the time and rigor necessary to achieve
23 clinical competence. However, business knowledge is vitally important to the sustainability of a
24 private medical practice given the necessary decisions which need to be made by the physician
25 owners. Young physicians who feel uncomfortable due to poor exposure to the basic skills
26 necessary to run an independent practice may perceive employment as a more stable alternative.

27 28 Evolving Lifestyle Preference of Early Career Physicians

29
30 A 2017 AMA and M3 Global Research survey found that 92 percent of physicians aged 35 and
31 younger rated work-life balance as a priority. Nearly four out of five said they eventually hoped to
32 seek out fields beyond patient care, including entrepreneurship, health care consultancy,
33 hospital/health system executive management, and academic research.²¹ These findings were
34 echoed by the younger physicians in the 2023 AMA “Illuminating the Physician Practice
35 Transition Journey” study, wherein participants reported that “being a physician is no longer the
36 only way they define themselves.” Although private practice is constantly evolving, the perception
37 that private practice offers “little separation between work and life” and no opportunities beyond
38 patient care persists. These changing life priorities and fixed perception of private practice may
39 contribute to younger physicians choosing employment.

40 41 Educational Debt of Early Career Physicians

42
43 The average medical school debt balance rose from about \$180,000 in 2015 to \$216,659 in 2025,
44 with 70 percent of 2025 graduates taking on student loan debt.²² While there is more extensive
45 literature describing the amount of educational debt driving decisions regarding specialty and
46 location (i.e., rural practices), it logically follows that an increased debt load may drive a physician
47 to the perceived relative financial stability of a salaried employment arrangement and away from
48 the potential financial instability of private practice. Additionally, some larger organizations offer
49 loan repayment as a potential recruiting tool to make employment more attractive.

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

6 7 *Interplay of Factors*

8
9 The factors discussed likely do not affect the decline of private medical practice independently.
10 Rather, the factors most likely interact in a dynamic fashion. It is important that policymakers and
11 stakeholders understand the interplay between these factors to identify and prioritize effective
12 interventions such as AMA-recommended reforms to promote site-neutral payment policies that
13 base reimbursement on the cost of a service rather than its location, modernize physician payment
14 through increased rates and inflation-based annual updates, and greater transparency of facility fees
15 at HOPDs. The following discussion outlines how most of the factors may contribute to a
16 reinforcing feedback loop, either directly, or as an accelerant.

17 18 Private Practice Margins are Compressed by Economic Pressures

19
20 Most private, independent physician-owned practices are small, so efficiencies gained from
21 economies of scale are not available to decrease overhead costs. Therefore, the effects of
22 decreasing reimbursement rates and loss of revenue streams to larger consolidated health care
23 organizations are causing a continued loss of the margin required to financially sustain practice.
24 Innovative mitigation of financial risk is hindered by regulatory burdens as costs associated with
25 compliance are significant and burdensome. In addition, the lack of formal business education also
26 hampers physicians from finding solutions to these economic stressors although even formal
27 business education would not negate the realities of the economic imbalance, decreasing revenues,
28 increasing costs, and restrictive structural barriers (e.g., increasing administrative and regulatory
29 burdens).

30 31 Physicians' Concern about Private Practice Viability Accelerates the Move to Employment or 32 Retirement

33
34 These unmitigated economic pressures coupled with increasing administrative burdens decrease the
35 attractiveness of private practice to physicians as compared to the perceived economic stability
36 (including additional revenue generated from the site-of-service differential) and decreased
37 administrative burden promised by other practice modes. This is accentuated by limited exposure
38 to private practice in training and the changes in generational preferences in lifestyle as well as a
39 high educational debt load. Many physicians have sought financial stability and decreased
40 administrative burden by retiring or becoming employed by—or selling their practices to—large
41 health systems.

42 43 Health Care Market Becomes More Consolidated, Exacerbating and Compounding the Cycle

44
45 As health care delivery and payment policy has become more complex, consolidation among
46 hospitals, health systems and physician practices has occurred. Dominant health insurers also limit
47 independent physicians' ability to negotiate, furthering a relative decrease in reimbursement rates
48 and loss of revenue streams as compared to health systems in dominant positions. This exacerbates
49 financial pressures on independent practices, further compounding the cycle that drives
50 consolidation.

1 AMA RESOURCES AND ACTIVITIES

2
3 With all the above factors, the AMA has made significant efforts to address the issues called out in
4 Policy D-405.965 regarding education, advocacy, and other activities.

5
6 *Medicare payment reform advocacy*

7
8 The AMA has identified Medicare physician payment reform as a top advocacy priority.²³ Through
9 sustained advocacy such as the [“Fix Medicare Now”](#) campaign—which in 2025 generated over
10 100,000 contacts to Congress and experienced a 36 percent increase in visitors to the site—AMA
11 and its partners have raised awareness among policymakers about the growing gap between the
12 cost of delivering care and Medicare reimbursement. Federal advisory bodies have echoed these
13 concerns. For instance, in its June 2025 report to Congress, MedPAC warned that the gap between
14 what Medicare pays and physicians’ practice costs could threaten patient access to care, and the
15 Medicare Trustees similarly projected that access to Medicare-participating physicians could
16 become a significant long-term issue if this gap persists. In response to these pressures, Congress
17 recently provided a one-time 2.5 percent Medicare payment update for 2026 in the One Big
18 Beautiful Bill Act (H.R. 1), while MedPAC recommended an additional 0.5 percent payment
19 update for 2027 on top of updates already specified in law.²⁴

20
21 Recent AMA efforts also comprise several advocacy measures concerning the site-of-service
22 differential. For example, in 2024, AMA authored an [issue brief](#) on this payment differential
23 between physician offices and ambulatory surgical centers versus HOPDs. The brief highlighted
24 that while physician Medicare pay rose eight percent (declined 29 percent when adjusted for
25 inflation) between 2001 and 2024, hospital Medicare pay rose over 70 percent over that same
26 period—despite CMS attempts at site neutrality since 2017. The brief presented several key points
27 for reform including payment based on the cost of a service rather than its location, increasing
28 physician payments (as opposed to just cutting hospital payment), adding inflation-based annual
29 updates, and encouraging care in lower-cost settings.²⁵

30
31 Additionally, in [Section 6225 of the Consolidated Appropriations Act, 2026](#)—a government bill
32 recently signed into law—Congress included a provision that’s consistent with AMA Policy D-
33 330.891, [“Transparency of Facility Fees for Hospital Outpatient Department Visits”](#) which
34 advocates for (1) legislation or regulation that mandates the proactive transparency of the added
35 costs to the consumer for health care services rendered at HOPD designated clinics and (2) the
36 additional costs of facility fees over professional services be stated upon scheduling of such
37 services, noting the two are separate and additive charges, as well as prominently displayed at the
38 point of service. Section 6225 requires all off-campus outpatient departments to obtain separate,
39 unique National Provider Identifiers and submit an attestation confirming compliance with
40 provider-based regulations by January 1st, 2028, or otherwise face the loss of OPSS payments.²⁶

41
42 Further, in 2025, CMS proposed and finalized the expansion of its policy of paying the MPFS
43 equivalent site neutral rate (40 percent of the OPSS rate) for drug administration services furnished
44 in excepted, off-campus HOPDs. The AMA provided [their comments](#) to CMS in September 2025,
45 supporting site-neutral outpatient policies in principle, but not if they reduce total Medicare
46 funding or ignore inadequate physician payment and resulting patient access risks. Rather, the
47 AMA clarified its support of competition in health care so patients have choices for where to
48 receive care but argued that true site neutrality requires raising and modernizing physician
49 payment, not cutting payments overall or shifting financial and other access-related burdens onto
50 patients and physicians.²⁷

1 *Monitoring of market dynamics*

2
 3 At the 2024 Annual meeting, [Council on Medical Service Report 4: “Health System](#)
 4 [Consolidation”](#) summarized main findings from the AMA’s Policy Research Perspective,
 5 “Competition in Hospital Markets, 2013–2021”, developed in response to Policy D-160.907 which
 6 directed the AMA to assess nationwide health system consolidation. Overall, the findings indicated
 7 that nearly all U.S. hospital markets are highly concentrated, with consolidation trends continuing
 8 to increase market concentration.²⁸

9
 10 Additionally, the AMA’s Division of Economic and Health Policy Research conducts independent
 11 analyses of competition in health insurance, pharmacy benefit manager, and hospital markets. One
 12 of the Division’s most significant efforts is its annually updated Competition in Health Insurance
 13 (CHI) study—the only publication of its kind. This study uses comprehensive national enrollment
 14 data to assess insurer market dynamics.²⁹ The [2025 update of this study](#) examined market
 15 concentration across 384 MSAs, all 50 states, and the District of Columbia using 2024 enrollment
 16 data and the HHI. The study found that U.S. health insurance markets remain overwhelmingly
 17 concentrated—97 percent of MSA-level commercial markets were highly concentrated in 2024,
 18 with an average HHI of 3486, and in nearly half of markets a single insurer held at least a 50
 19 percent market share. Market concentration has generally increased between 2014 and 2024, and
 20 Medicare Advantage markets also remain highly concentrated.¹⁶

21
 22 *Decreasing administrative and regulatory burdens*

23
 24 The AMA also provides physicians, care teams and health care leadership with resources designed
 25 to promote professional satisfaction, efficient use of digital health technology, practice
 26 sustainability, and quality patient care through its [STEPS Forward®](#) Innovation Academy.
 27 Resources are offered in the form of playbooks, toolkits, webinars, podcasts, and bootcamps on
 28 topics such as private practice, physician burnout, and time-saving strategies.³⁰

29
 30 Further, the AMA’s [Debunking Regulatory Myths series](#) provides physicians and care teams with
 31 regulatory clarification to reduce guesswork and administrative burden in their day-to-day practice,
 32 helping streamline clinical workflows, improve patient outcomes, and enhance physician
 33 satisfaction. The series focuses on topics such as billing/coding, documentation, EHR
 34 interoperability, Joint Commission and CMS guidance, and scope of practice laws.³¹

35
 36 *Support of Private Practice*

37
 38 The High-Performing Private Practice Initiative launched in 2021 to enhance the AMA’s efforts to
 39 address a concerning trend—[a decline in physician practice ownership from 54 percent in 2018 to](#)
 40 [49.1 percent in 2020](#).³² A 2021 AMA-Mathematica study of 25 high-performing practices
 41 identified critical barriers, including professional isolation and insufficient business management
 42 education among recent graduates.³³

43
 44 The AMA initiative created essential resources to support private practice. Between 2021 and
 45 2022, the team developed the [Private Practice web toolkit](#), the [Simple Solutions](#) educational series,
 46 the [Thriving in Private Practice podcast](#), and the [Private Practice Playbook](#). The [Navigating](#)
 47 [Practice](#) series introduced medical students to independent practice as a viable career path. By
 48 2023-2024, programming expanded with the [STEPS Forward Attending to Business](#) podcast. The
 49 June 2024 workshop addressing business skills in private practice represented a pivotal evolution
 50 from passive resources to active business education. As part of this program, educational modules
 51 were curated so physicians could become exposed to introductory level business skills and

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

4
5 These early efforts revealed that physicians lacked comprehensive support for launching
6 independent practices. The [Independent Practice Incubator](#) pilot filled this gap as a first-of-its-kind
7 12-month immersion program covering essential competencies for independent practice. The first
8 cohort received education to adopt innovative private practice models, including several that were
9 designed to serve underrepresented and underserved communities.

10
11 Based on learnings from the Incubator pilot, the AMA is now scaling this program and, in the fall
12 of 2026, the Independent Practice Forum—a two-day intensive workshop distilling essential
13 competencies through expert sessions, case studies, and peer networking—will launch. This
14 accessible format will provide physicians exploring or beginning independent practice with
15 foundational knowledge in strategic planning, obtaining capital, business fundamentals, revenue
16 cycle management, operations, leadership, and marketing.

17
18 The AMA will now offer a complete ecosystem—foundational resources, community building, and
19 education spanning from medical school through practice launch. This multi-tiered approach—
20 combining ongoing education, immersion programs, and intensive workshops—establishes the
21 AMA as the primary resource for independent practice physicians. By preserving physician choice
22 and practice model diversity, the program ensures that AMA's core mission of removing obstacles
23 to patient care and ensuring high-quality care delivery remains accessible despite increasing health
24 care consolidation.

25 26 AMA POLICY

27
28 The following emphasizes the breadth of AMA policies aimed at addressing the factors
29 contributing to the decline of private practice including: Medicare reimbursement, the site-of-
30 service differential, inflation-based physician payment, health system and insurance consolidation,
31 the preservation of private practice, and administrative burden.

32 33 *Medicare Reimbursement*

34
35 Regarding the importance of improved Medicare and Medicaid reimbursement, the AMA (1)
36 continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient
37 access to care and undermine the quality of care provided to patients; (2) supports the concept that
38 the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of
39 living, the growing size of the Medicare population, and the cost of new technology; (3)
40 aggressively encourages CMS to affirm the patient's and the physician's constitutional right to
41 privately contract for medical services; notes that (4) if the reimbursement is not improved, our
42 AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate
43 legislation to allow the physician to balance bill the patient according to their usual and customary
44 fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid,
45 Medicare, and other appropriate health care reimbursement programs, in addition to other needed
46 payment increases ([Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement"](#)).

47
48 The AMA will also (1) encourage CMS to expand the extent and amount of reimbursement for
49 procedures performed in the physician's office, to shift more procedures from the hospital to the
50 office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs
51 reflect the true cost of performing office procedures; (3) work with CMS to develop consistent

1 regulations to be followed by carriers that include reimbursement for the costs of disposable
2 supplies and surgical tray fees incurred with office-based procedures and surgery; (4) support the
3 Current Procedural Terminology (CPT®) Editorial Panel / RVS Update Committee (RUC)
4 recommendation to the Centers for Medicare & Medicaid Services (CMS) to separately pay for
5 high-cost supplies priced more than \$500; and (5) work with the federal government to address
6 flaws in the Medicare Physician Fee Schedule practice expense methodology resulting in
7 reimbursement being less than direct costs for hundreds of services in the office-based setting
8 ([Policy H-400.957, “Medicare Reimbursement of Office-Based Procedures”](#)).

9
10 Further, the AMA urges CMS to permit separate reimbursement for medically necessary multiple
11 visit services rendered to Medicare patients on the same day by the same physician regardless of
12 the setting in which those services were provided ([Policy H-390.879, “Medicare Reimbursement
13 for Multiple Physician's Visits on the Same Day Regardless of the Place of Service”](#)).

14 *Site-of-Service Differential*

15
16
17 Concerning the site-of-service differential, AMA (1) supports Medicare payment policies for
18 outpatient services that are site-neutral without lowering total Medicare payments and Medicare
19 payments for the same service routinely and safely provided in multiple outpatient settings (e.g.,
20 physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the
21 actual costs of providing the service in each setting; (2) will urge the CMS to update the data used
22 to calculate the practice expense component of the Medicare physician fee schedule by
23 administering a physician practice survey (similar to the Physician Practice Information Survey
24 administered in 2007-2008) every five years, and that this survey collect data to ensure that all
25 physician practice costs are captured; (3) encourages CMS to both: base disproportionate share
26 hospital payments and uncompensated care payments to hospitals on actual uncompensated care
27 data; and study the costs to independent physician practices of providing uncompensated care; (4)
28 will collect data and conduct research to both: document the role that physicians have played in
29 reducing Medicare spending; and facilitate adjustments to the portion of the Medicare budget
30 allocated to physician services that more accurately reflects practice costs and changes in health
31 care delivery; and (5) will disseminate educational materials and graphics and promote awareness
32 that the site-of-service payment differential is not based on the quality of care provided across
33 outpatient care settings ([Policy D-330.902, “The Site-of-Service Differential”](#)).

34
35 Further, AMA will advocate to prohibit insurers from denying or reducing payment for a procedure
36 based solely on the site of service in which was performed, provided that the procedure is
37 medically necessary and can safely be performed in that location ([Policy H-240.958, “Prohibiting
38 Insurers from Denying Payment for Procedures Based on Site of Service”](#)).

39
40 AMA will also work with states to advocate that third party payers be required to: a. Assess equal
41 or lower facility coinsurance for lower-cost sites of service (hospital outpatient department,
42 ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent
43 information related to patient cost-sharing; and c. Allow their plan's participating physicians to
44 perform outpatient procedures at an appropriate site of service as chosen by the physician and the
45 patient ([Policy D-240.994, “Payment Variations Across Outpatient Sites of Service”](#)).

46
47 Further, the AMA encourages CMS to: (A) define Medicare services consistently across settings
48 and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital
49 outpatient departments and other ambulatory settings; and (B) adopt payment methodology for
50 hospital outpatient departments and ambulatory surgical centers that will assist in leveling the
51 playing field across all sites-of-service. If necessary, the AMA should consider seeking a

1 legislative remedy to the payment disparities between hospital outpatient departments and
2 ambulatory surgical centers. AMA will continue to encourage the CMS to collect data on the
3 frequency, type and cost of services furnished in off-campus, provider-based departments ([Policy](#)
4 [D-330.997, “Appropriate Payment Level Differences by Place and Type of Service”](#)).

5
6 *Inflation-Based Physician Payment*

7
8 On the topic of inflation-adjusted physician payment rates, AMA policy states that it shall use
9 every means available to convince health insurance companies and managed care organizations to
10 immediately uncouple fee schedules from the Medicare Physician Payment Schedule and to
11 maintain a level of payment that is sustainable, reflects the full cost of practice, and the value of the
12 care provided, and includes inflation-based updates; and AMA will seek legislation and/or
13 regulation to prevent managed care companies from utilizing a physician payment schedule below
14 the updated Medicare Physician Payment Schedule ([Policy D-400.990, “Uncoupling Commercial](#)
15 [Fee Schedules from the Medicare Physician Payment Schedule”](#)).

16
17 Additionally, AMA supports policy that increases and maintains access to health care for all,
18 payment for physicians under Medicaid, TRICARE, and any other publicly funded insurance plan
19 must be sustainable, reflect the full cost of practice and the value of the care provided, include
20 inflation-based updates, and pay no less than 100 percent of RBRVS Medicare allowable ([Policy](#)
21 [H-385.921, “Health Care Access for Medicaid Patients”](#)).

22
23 *Health System & Insurance Consolidation*

24
25 AMA has numerous policies regarding health system and insurance consolidation. For instance, the
26 AMA (1) will assess and report annually on nationwide health system and hospital consolidation,
27 as well as payer consolidation, to assist policymakers and the federal government; and this AMA
28 annual report on nationwide hospital consolidation will be modeled after the “Competition in
29 health insurance: A comprehensive study of U.S. Markets” in its thoroughness to include for
30 example data and analyses as: (a) a review of the current level of hospital and/or health system
31 consolidation at the level of all metropolitan statistical areas, state, and national markets; (b) a list
32 of all mergers and acquisition transactions valued above a set threshold amount resulting in
33 hospital and/or health system consolidation; (c) analyses of how each transaction has changed or is
34 expected to change the level of competition in the affected service and geographic markets; and (d)
35 analyses of healthcare costs and prices have changes in affected markets after a large consolidation
36 transaction has taken place. AMA will report the initial findings of this study to the House of
37 Delegates by Annual 2024 and the findings of this study to its members and stakeholders, including
38 policymakers and legislators, to inform future healthcare policy ([Policy D-160.907, “Health](#)
39 [System Consolidation”](#)).

40
41 The AMA will also study nationwide health system and hospital consolidation in order to assist
42 policymakers and the federal government in assessing healthcare consolidation for the benefit of
43 patients and physicians who face an existential threat from healthcare consolidation; and will
44 regularly review and report back on these issues to keep the House of Delegates apprised on
45 relevant changes that may impact the practice of medicine, with the first report no later than the
46 2023 Annual Meeting ([Policy D-215.984, “Health System Consolidation”](#)).

47
48 Further, the AMA opposes consolidation in the health insurance industry that may result in
49 anticompetitive markets ([Policy H-180.947, “Maintaining Freedom of Choice with Insurance](#)
50 [Products”](#)).

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

4
 5 Likewise, the AMA advocates against anticompetitive business practices that have the potential to
 6 adversely affect the physician patient relationship, to result in higher costs or decreased quality of
 7 care, or are not in the best interest of patients, the public and/or physicians; and also supports
 8 efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers
 9 that have the potential to negatively impact the health care industry. AMA will work with all
 10 appropriate stakeholders to create model legislation to prohibit anticompetitive business practices
 11 within the health care sector ([Policy D-160.908, “Vertical Consolidation in Health Care – Markets](#)
 12 [or Monopolies”](#)).

13
 14 The AMA also (1) recognizes the substantial impact of the Stark law’s unequal restrictions on
 15 independent physicians, contributing to the growing trend of hospital consolidation, which has led
 16 to negative consequences of restricted access to care and inflated costs; (2) supports comprehensive
 17 Stark law reform aimed at rectifying the disparities that disadvantage independent physician
 18 practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, “Physician Self-
 19 Referral”; and (3) supports equitable and balanced Stark law reform that fosters fair competition,
 20 incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care ([Policy D-](#)
 21 [385.940, “Stark Law Self-Referral Ban”](#)).

22
 23 Further, the AMA affirms that: (a) health care entity mergers should be examined individually,
 24 taking into account case-specific variables of market power and patient needs; (b) strongly supports
 25 and encourages competition in all health care markets; (c) supports rigorous review and scrutiny of
 26 proposed mergers to determine their effects on patients and providers; and antitrust relief for
 27 physicians remains a top AMA priority. AMA will continue to support actions that promote
 28 competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the
 29 ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for
 30 physician practices to compete; and (d) achieving meaningful price transparency. AMA will work
 31 with interested state medical associations to monitor hospital markets, including rural, state, and
 32 regional markets, and review the impact of horizontal and vertical health system integration on
 33 patients, physicians and hospital prices ([Policy H-215.960, “Hospital Consolidation”](#)).

34
 35 It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or
 36 affiliation, a joint committee with merging medical staffs should be established to resolve at least
 37 the following issues: (a) medical staff representation on the board of directors; (b) clinical services
 38 to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d)
 39 selection of the medical staff officers, medical executive committee, and clinical department chairs;
 40 (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality
 41 improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for
 42 physician services and their impact on physicians' clinical privileges; (i) conflict resolution
 43 mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of
 44 medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed
 45 as binding contracts between the medical staffs and the hospitals. AMA will also work to ensure,
 46 through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead
 47 to restrictions on reproductive health care services, the merging entity shall be responsible for
 48 ensuring continuing community access to these services ([Policy H-215.969, “Hospital Merger](#)
 49 [Study”](#)).

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

8
9 Further, AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions
10 that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to
11 enable physicians to consolidate in a manner to insure a viable governance structure and equitable
12 distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited
13 collective bargaining; and (3) find and improve business models for physicians to improve their
14 ability to maintain a viable economic environment to support community access to high quality
15 comprehensive healthcare ([Policy H-383.988, "Physicians' Ability to Negotiate and Undergo
16 Practice Consolidation"](#)).

17
18 In addition, AMA will (1) continue to monitor the impact of hospital-physician practice and
19 hospital-hospital mergers and acquisitions on health care prices and spending, patient access to
20 care, potential changes in patient quality outcomes, and physician wages and labor; (2) continue to
21 monitor how provider mix may change following mergers and acquisitions and how non-compete
22 clauses may impact patients and physicians; (3) support efforts to collect relevant information
23 regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or
24 regions that may fall below the FTC/DOJ review threshold; (4) encourage state and local medical
25 associations, state specialty societies, and physicians to contact their state attorney general with
26 concerns of anticompetitive behavior; and (5) encourage physicians to share their experiences with
27 mergers and acquisitions, such as those between hospitals and/or those between hospitals and
28 physician practices, with the FTC via their online submission form ([Policy H-160.885, "Impact of
29 Integration and Consolidation on Patients and Physicians"](#)).

30
31 It is also AMA policy that when a private medical practice is purchased by corporate entities,
32 patients going to that practice shall be informed of this ownership arrangement by the corporate
33 entities and/or by the physician ([Policy H-160.960, "Corporate Ownership of Established Private
34 Medical Practices"](#)).

35 36 *Preservation of Private Practices*

37
38 Concerning the preservation of private practice, AMA policy states that the AMA (1) supports
39 preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its
40 resources to protect and support the continued existence of solo and small group medical practice,
41 and to protect and support the ability of these practices to provide quality care; (3) will advocate in
42 Congress to ensure adequate payment for services rendered by private practicing physicians; (4)
43 will work through the appropriate channels to preserve choices and opportunities, including the
44 private practice of medicine, for new physicians whose choices and opportunities may be limited
45 due to their significant medical education debt; (5) will work through the appropriate channels to
46 ensure that medical students and residents during their training are educated in all of medicine's
47 career choices, including the private practice of medicine; (6) will create, maintain, and make
48 accessible to medical students, residents and fellows, and physicians, resources to enhance
49 satisfaction and practice sustainability for physicians in private practice; (7) will create and
50 maintain a reference document establishing principles for entering into and sustaining a private
51 practice, and encourage medical schools and residency programs to present physicians in training

1 with information regarding private practice as a viable option; and (8) will issue a report in
2 collaboration with the Private Practice Physicians Section at least every two years communicating
3 their efforts to support independent medical practices ([Policy D-405.988, “The Preservation of the](#)
4 [Private Practice of Medicine”](#)).

5
6 Additionally, our AMA will (1) inform corporate efforts about the value of private practices to
7 successfully participate in new “value-based” models; (2) identify and work with a corporate entity
8 that is advancing these models to explore a two year pilot among independent private practices in
9 which our AMA will: (a) convene physician practices in a community; (b) provide educational
10 resources and technical assistance to practices to support their participation with the corporate
11 entity; (c) formally evaluate the pilot for outcomes; and (3) will advocate with commercial payers
12 and health plans and federal and state payers and policymakers to support private practice through
13 policies and models that provide adequate payment, infrastructure and data to succeed in “value-
14 based” models ([Policy D-160.909, “Advocacy of Private Practice Options for Healthcare](#)
15 [Operations in Large Corporations”](#)).

16
17 *Administrative Burdens*

18
19 Also of importance to discuss are AMA policies on administrative burden. Such policy states that
20 the AMA will perform or commission an analysis of the direct and indirect costs and documented
21 benefits associated with significant administrative and regulatory requirements imposed by the
22 CMS, including but not limited to face-to-face documentation requirements, the Physician Quality
23 Reporting System, and the Meaningful Use program ([Policy D-330.909, “Study the Costs of](#)
24 [Administrative and Regulatory Burdens”](#)).

25
26 Furthermore, AMA supports accurate calculations of the administrative costs of government
27 programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy
28 of the AMA: (1) to begin immediately to seek comprehensive reforms to reduce the administrative
29 inefficiencies, burdens and expenses involved in paying for health care services and to urge that
30 proposals to increase access to health care also address the need to reduce administrative costs and
31 burdens; (2) that state and county medical societies and national medical specialty societies be
32 urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health
33 care payers directed toward improving the efficiency of utilization management programs and
34 minimizing the administrative burdens they impose on physicians and hospitals; (3) that the AMA
35 strongly encourage further study of the cost-effectiveness of all types of utilization management
36 systems and programs and report further results of such study to the Federation as they become
37 available; (4) that state medical societies be urged to work for enactment of the AMA model state
38 legislation governing: (a) clarity and readability of contract language and uniform policy
39 provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in
40 the review process; and (d) confidentiality of medical information requested by review entities; and
41 (5) that this information be conveyed to the American public through appropriate mechanisms
42 ([Policy H-155.976, “Administrative Costs and Access to Health Care”](#)).

43
44 CONCLUSION

45
46 This root cause analysis concerning the causes of the decline of private medical practice is a
47 helpful reexamination that can serve as a catalyst for continued and enhanced action. The framing
48 of potential causes into the four categories of economic pressures, market consolidation,
49 administrative and regulatory burden, and generational workforce factors can help contextualize
50 the factors delineated in the resolution as well as any other newly identified potential factors.

1 Understanding the interplay between the factors is also helpful in identifying and prioritizing
2 effective interventions.

3
4 The AMA has dedicated significant resources and other efforts in this area as specified in this
5 report. To more effectively leverage this body of work, AMA should enhance its communication
6 and engagement efforts to ensure private practice and AMA solutions are widely available to all
7 physicians. The findings of this report can potentially guide a more comprehensive strategy in this
8 communication and engagement so that these resources and efforts are not implemented in silos but
9 are mutually reinforcing to produce a more effective result.

10 11 RECOMMENDATIONS

12
13 The Board of Trustees recommends the following be adopted and the remainder of this report be
14 filed:

- 15
16 1. That our AMA reaffirm the following policies:
 - 17 a. H-330.932, "Cuts in Medicare and Medicaid Reimbursement";
 - 18 b. H-400.957, "Medicare Reimbursement of Office-Based Procedures";
 - 19 c. H-390.879, "Medicare Reimbursement for Multiple Physician's Visits on the Same
20 Day Regardless of the Place of Service";
 - 21 d. D-330.902, "The Site-of-Service Differential";
 - 22 e. H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site
23 of Service";
 - 24 f. D-240.994, "Payment Variations Across Outpatient Sites of Service"; D-330.997,
25 "Appropriate Payment Level Differences by Place and Type of Service";
 - 26 g. D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician
27 Payment Schedule";
 - 28 h. H-385.921, "Health Care Access for Medicaid Patients";
 - 29 i. D-160.907, "Health System Consolidation";
 - 30 j. D-215.984, "Health System Consolidation";
 - 31 k. H-180.947, "Maintaining Freedom of Choice with Insurance Products";
 - 32 l. D-160.906, "Strengthening Efforts Against Horizontal & Vertical Consolidation";
 - 33 m. D-160.908, "Vertical Consolidation in Health Care – Markets or Monopolies";
 - 34 n. D-385.940, "Stark Law Self-Referral Ban";
 - 35 o. H-215.960, "Hospital Consolidation";
 - 36 p. H-215.969, "Hospital Merger Study";
 - 37 q. D-225.995, "Hospital Merger Study";
 - 38 r. H-383.988, "Physicians' Ability to Negotiate and Undergo Practice Consolidation";
 - 39 s. H-160.885, "Impact of Integration and Consolidation on Patients and Physicians";
 - 40 t. H-160.960, "Corporate Ownership of Established Private Medical Practices";
 - 41 u. D-405.988, "The Preservation of the Private Practice of Medicine";
 - 42 v. D-160.909, "Advocacy of Private Practice Options for Healthcare Operations in Large
43 Corporations";
 - 44 w. D-330.909, "Study the Costs of Administrative and Regulatory Burdens";
 - 45 x. H-110.985, "340B Drug Discount Program"; and
 - 46 y. H-155.976, "Administrative Costs and Access to Health Care" (Reaffirm HOD Policy)
- 47 2. Our AMA will identify stakeholders to expand physician awareness of and engagement with
48 AMA private practice resources and solutions. (New HOD Policy)
- 49 3. That Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical
50 Practice" be rescinded as being accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

APPENDIX:

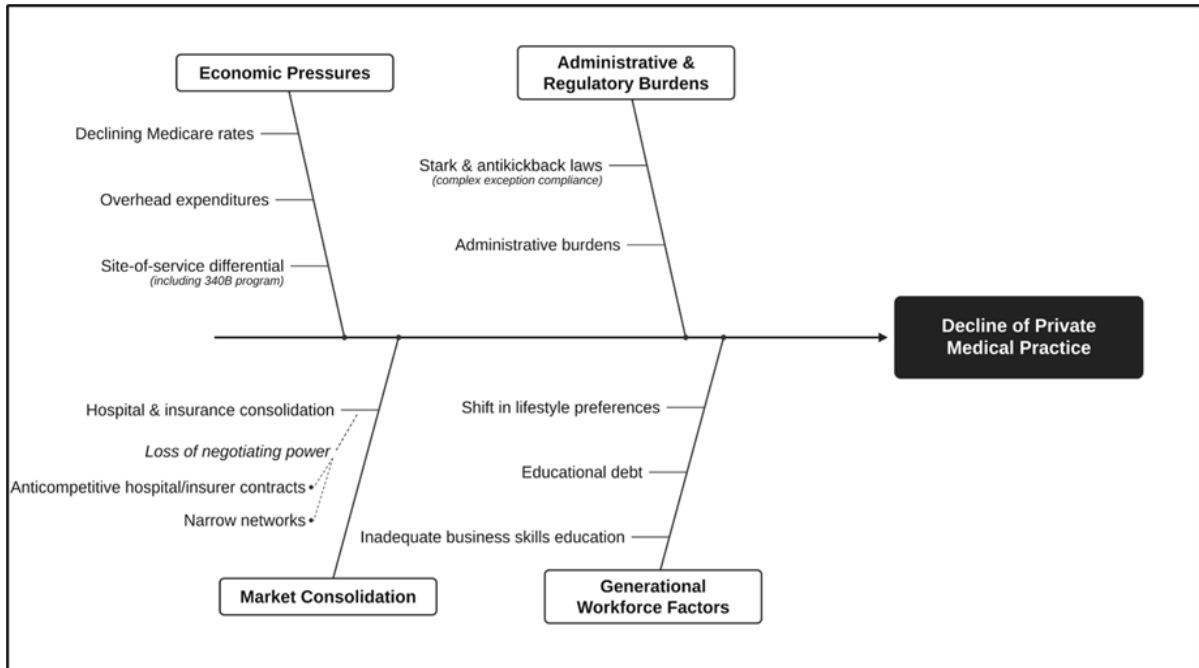


Figure 1: Basic root cause analysis fishbone diagram⁷ used by report authors to organize the factors outlined in Policy D-405.965 into overarching thematic categories.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 21-A-26

Subject: Abolishing Venue Shopping
(Resolution 207-A-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

- 4
- 5 1. That our American Medical Association oppose venue shopping in medical
6 professional liability actions; and be it further
7
 - 8 2. That our AMA study avenues to most effectively combat venue shopping in state and
9 federal medical professional liability actions with report back at A-26.

10

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

20

21 **BACKGROUND**

22

23 Medical liability reform has long been one of the AMA’s advocacy priorities. Although physicians
24 and patients are not yet experiencing the kind of national medical liability insurance crisis that
25 occurred in the early 2000s, over the last few years there has been a significant increase in the size
26 of medical liability awards. In fact, the U.S. has seen an increase of “nuclear verdicts” in medical
27 liability cases, i.e., cases where the jury awarded \$10 million or more, some exceeding \$25 million.
28 This is worrisome to the Board of Trustees (the Board) because such awards are often influenced
29 by factors that have nothing to do with a physician’s alleged negligence or patient injury.
30 Oftentimes they are the product of “social inflation,” such as eroding trust in the U.S. health care
31 system and the perceived corporatization of medicine. There also appears to be a return of hard
32 medical liability insurance markets in parts of the country.

1 In addition to what has been described above, the Board knows that venue shopping, also known as
2 forum shopping, can be a major contributor to increasing medical liability exposure. Venue
3 shopping occurs when a plaintiff's attorney can file medical liability lawsuits in a county where
4 juries are known for awarding large medical liability awards, even if the county has no connection
5 to underlying facts of the lawsuit. Venue shopping is an abuse of the judicial process, as it leads to
6 outsized awards that must be absorbed by physicians in the form of increased medical liability
7 insurance premiums, ultimately to the detriment of patient access.

8
9 Based on the above, the Board understands that the need to enact medical liability reform is urgent
10 in some states.

11
12 *State Medical Liability Lawsuits and Forum Shopping: The Pennsylvania Example*

13
14 After evaluating state environments across the country, it is clear that Pennsylvania physicians
15 have suffered the most harm from venue shopping in medical liability cases. Notably, in the early
16 2000s, Pennsylvania experienced a severe medical liability crisis. Much of the crisis was the result
17 of plaintiffs' attorneys filing medical liability cases in Philadelphia County and Allegheny County,
18 where juries were notoriously plaintiff friendly.

19
20 Because Pennsylvania has been ground zero of venue shopping abuse and has led the way in efforts
21 to combat venue shopping, the Board believes that closely analyzing the Pennsylvania experience
22 is the best way to conduct the study called for by Policy D-435.968.

23
24 During its medical liability crisis, Pennsylvania pursued at least two strategies to combat venue
25 shopping. First, Pennsylvania enacted 42 Pa.C.S.A. § 5101.1. This statute required medical liability
26 cases to be filed "only in a county in which the cause of action arose." This statute was, however,
27 declared unconstitutional in *North-Central Pennsylvania Trial Lawyers Association v. Weaver*,
28 827 A.2d 550 (Pa. Cmmwth. 2003) on the grounds that Pennsylvania's judicial branch of
29 government, rather than the Pennsylvania General Assembly, was constitutionally authorized to set
30 venue rules.

31
32 Second, in 2002, Pennsylvania enacted the Medical Care Availability and Reduction of Error Act
33 (the MCARE Act). The MCARE Act established the Interbranch Commission on Venue (the
34 Commission), comprised of representatives from the legislative, judicial, and executive branches of
35 the Commonwealth of Pennsylvania, and others. In 2003, on recommendations from the
36 Commission, the Supreme Court of Pennsylvania adopted a civil procedure rule, Rule 1006(a)(1),
37 requiring medical liability cases to be filed in the county in which the cause of action arose.
38 Rule 1006(a)(1) was instrumental in stabilizing the medical liability insurance market in
39 Pennsylvania.

40
41 Notably, on August 25, 2022, however, the Supreme Court of Pennsylvania, following
42 recommendations of the Civil Procedural Rules Committee (Civil Rules Committee), whose
43 members are appointed by the Supreme Court of Pennsylvania, issued an order amending Rule
44 1006. The amendments eliminated the requirement that medical liability lawsuits had to be filed in
45 the county where the cause of action arose. Due to this decision, like other lawsuits, medical
46 liability lawsuits in Pennsylvania may now, once again, be forum shopped since lawsuits may be
47 filed where a defendant may be served, the cause of action arose, or a transaction or occurrence
48 took place out of which the cause of action arose. After the amendments to Rule 1006 were
49 adopted, the Board would like to note that there was a four-fold increase in the number of
50 malpractice lawsuits filed in Philadelphia County. Moreover, between January 2023 and April

1 2023, 43 percent of 657 medical malpractice complaints that were initiated in Philadelphia County
2 were based on care provided outside the city.¹

3
4 The Board believes that it is likely that restoring plaintiffs' attorneys' ability to venue shop medical
5 liability cases in Pennsylvania will undermine the stability of the medical liability insurance market
6 in the state.

7
8 Venue Shopping and Resourced-Based Standards of Care

9
10 Venue shopping may hit physicians that practice in rural or underserved communities and their
11 patients particularly hard, since these physicians often have fewer resources, limited staff, and less
12 advanced medical equipment compared to those within larger health care systems. It may be
13 logistically impossible for rural physicians to perform certain procedures or make needed referrals
14 due to lack of availability within the community. These and similar resource constraints must be
15 considered when determining the standard of care relevant to any medical liability allegations.
16 Juries in some parts of a state, e.g., a well-resourced city with four Level-1 trauma centers, may
17 know nothing about the resource limitations under which rural physicians must practice, and thus
18 apply a standard of care that is appropriate to physicians practicing in that city but wholly
19 inappropriate to a rural practice setting. Rural physicians whose liability is determined by juries
20 having no appreciation for their unique practice environments are likely to be held responsible for
21 harm resulting from factors far outstripping their control or even influence. To ensure fairness,
22 AMA policy should state that the AMA opposes venue shopping resulting in the application of a
23 standard of care that is not specifically linked to the physical resources, technology and specialty
24 support available at the site of patient care delivery.

25
26 *Federal Medical Professional Liability Actions and Venue Shopping*

27
28 Federal medical professional liability actions are brought under the Federal Tort Claims Act
29 (FTCA).² A medical liability lawsuit under the FTCA may be commenced only in the judicial
30 district where the plaintiff resides or wherein the act or omission complained of occurred.³ Thus, it
31 does not appear that federal medical professional liability actions raise the kinds of venue shopping
32 concerns that may exist in state law. This does not mean, however, that attempts might be made in
33 the future to alter the FTCA to permit venue shopping. The AMA would vehemently oppose such
34 efforts.

35
36 Given that current venues for federal medical professional liability actions under the FTCA appear
37 to provide little opportunity for venue shopping, the remainder of this report will focus on state
38 venue issues.

39
40 DISCUSSION

41
42 Policy D-435.968 asks that the AMA study avenues to most effectively combat venue shopping in
43 state and federal medical professional liability actions. At this point there appear to be at least three
44 strategies that might be used to combat venue shopping in states, all based on knowledge of and
45 insights taken from the Pennsylvania experience.

46
47 First, enacting a statute that restricts where medical professional liability lawsuits may be
48 filed is one strategy to combat venue shopping. As the *Weaver* case illustrates, however, such
49 statutes may be subject to constitutional challenges. Importantly, the Board notes that while
50 this is what happened to Pennsylvania's statute, the situation may be different in other states.
51 For example, in 2005, Missouri enacted R.S.,Mo. § 508.010, as part of a comprehensive

1 medical liability reform package. Section 508.010 establishes venue under different scenarios
 2 for both non-tort and tort claims (e.g., medical professional liability lawsuits). Section
 3 508.010 states in part that, “Notwithstanding any other provision of law, in all actions in
 4 which there is any count alleging a tort and in which the plaintiff was first injured in the state
 5 of Missouri, venue shall be in the county where the plaintiff was first injured by the acts or
 6 conduct alleged in the action.”

7
 8 In Missouri, venue is fixed in the county where the plaintiff was first injured by the alleged
 9 negligence. While the meaning and application of § 508.010 has been litigated many times, there
 10 appear to be no reported cases ruling that § 508.010 is unconstitutional. One cannot simply assume
 11 that the courts of any given state would decide that a statute like 42 Pa.C.S.A. § 5101.1 would be
 12 unconstitutional. In fact, in some states, enacting state laws prohibiting venue shopping might be a
 13 viable option to combat venue shopping.

14
 15 Second, if there are concerns about the constitutionality of a statutory approach, one could follow
 16 the Pennsylvania example and advocate for a law that would convene members of the legislative,
 17 judicial, and executive branches of government and other interested parties to see if the judicial
 18 branch would address venue shopping through court rules. While this approach succeeded in
 19 Pennsylvania, the Board warns that this strategy might not be as promising as a legislative solution
 20 since the decision of whether to implement (or implement and then repeal) such rules would lie
 21 entirely within the judicial branch’s discretion.

22
 23 A recent Pennsylvania court decision, *Somerlot v. Jung*, 343 A.3d 324, 333 (Pa. Super. 2025),
 24 suggests a third way to combat venue shopping. In this case, the plaintiff, Ms. Somerlot fell
 25 and injured one of her fingers. Due to pain and decreased range of motion she sought pain
 26 treatment from the defendant, Dr. Jung, whose office was in Bucks County Pennsylvania. Dr.
 27 Jung ultimately determined that Ms. Somerlot needed spinal cord surgery. Ms. Somerlot
 28 alleged to have received injuries during the surgery and filed a medical liability lawsuit
 29 against Dr. Jung in Philadelphia County, notwithstanding the fact that the Court of Common
 30 Pleas of Bucks County was less than two miles from Ms. Somerlot’s home.

31
 32 Notably, the facts showed that prior to surgery, Ms. Somerlot signed a “Consent to Operate,
 33 Administration of Anesthetics and Rendering of Medical Services.” This document included
 34 a venue selection clause stating in part that, “Any legal claims or civil actions, including, but
 35 not limited to, a claim for medical malpractice in any way related to this
 36 admission/procedure, and medical services shall be brought solely in the Courts of Bucks
 37 County, in the Commonwealth of Pennsylvania.”

38
 39 Because Ms. Somerlot signed the venue selection clause, Dr. Jung argued that Ms. Somerlot had to
 40 file her lawsuit in Bucks County, not Philadelphia County. Ultimately, the court agreed with Dr.
 41 Jung, stating that:

42
 43 Critically, the Civil Rules Committee omitted language or a Note to Rule 1006 reflecting
 44 the fact that Pennsylvania law has long recognized a contract-based exception to all Rule
 45 1006 on venue. The Supreme Court of Pennsylvania has made clear that parties may
 46 freely contract to limit venue to one of several available venues. The Supreme Court first
 47 recognized such an exception in *Central Contracting Co. v. C. E. Youngdahl & Co.*, 418
 48 Pa. 122, 209 A.2d 810 (Pa. 1965).

49
 50 Thus, based on Pennsylvania Supreme Court precedent and the fact that Ms. Somerlot consented to
 51 venue in Bucks County by signing the venue selection clause, the court transferred the case from

1 Philadelphia County to Bucks County. Based on this case, the Board believes that this contractual
2 approach is a strategy to combat venue shopping that may also be available in other states.

3
4 CONCLUSION

5
6 The Board is greatly concerned about recent, disturbing trends in medical liability, and this
7 includes venue shopping. The Board recognizes that advocacy efforts to combat venue shopping
8 may raise complicated issues. Regardless of issues raised, the Board believes that the AMA,
9 alongside its medical society partners, must do everything it can to enact effective medical liability
10 reforms at the state level, and this includes combating venue shopping.

11
12 The Board, therefore, recommends that the HOD modify existing policy D-435.968, “Abolishing
13 Venue Shopping,” and by adopting new policy focused on the AMA working with interested
14 medical societies in combating venue shopping in medical liability lawsuits. The Board also
15 recommends that the HOD modify D-435.968 “Abolishing Venue Shopping” by rescinding
16 language in the second resolve requiring that the AMA study avenues to most effectively combat
17 venue shopping in state and federal medical professional liability actions with report back at A-26,
18 since this report constitutes the required study.

19
20 RECOMMENDATION

21
22 The Board of Trustees recommends that the following recommendations be adopted, and the
23 remainder of the report be filed:

- 24
25 1. That our American Medical Association amend Policy D-438.968, “Abolishing Venue
26 Shopping” by deletion of clause 2 as it has been accomplished by this report:

27
28 1. Our American Medical Association (AMA) opposes venue shopping in medical
29 professional liability actions.

30
31 ~~2. Our AMA will study avenues to most effectively combat venue shopping in state and
32 federal medical professional liability actions with report back at A-26. (Modify Current
33 Policy)~~

- 34
35 2. That our AMA will work with interested medical society partners, to combat venue
36 shopping in medical liability lawsuits. (New HOD Policy)

- 37
38 3. That our AMA opposes any efforts to move venue to jurisdictions that may apply a
39 standard of care not reflecting specific resource constraints, available
40 technology/equipment and community standards of the location where the patient’s clinical
41 care was actually delivered. (New HOD Policy)

Fiscal Note: Less than \$500.

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² U. S. Code 28 U.S.C. §§ 1346(b), 2671-2680

³ 28 U.S. Code § 1402(b); §§ 2671-2680

REPORT OF THE BOARD OF TRUSTEES

BOT Report 24-A-26

Subject: AMA Advocacy to Mitigate Medicaid Cuts

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

- 4
- 5 1. Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the “One Big
6 Beautiful Bill Act of 2025”);
- 7 2. Through, but not limited to, press releases, position statements, op-eds in major outlets,
8 press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates
9 to Medicaid;
- 10 3. Continue working with state medical societies, specialty societies, patient advocacy
11 groups, hospital systems and safety net organizations to advocate for the reversal or
12 mitigation of Medicaid-related cuts in Public Law 119-21;
- 13 4. Report back to the AMA’s House of Delegates at A-26.
- 14

15 The Board of Trustees is pleased to report that the AMA has taken prompt and sustained action
16 consistent with this directive, including public condemnation of the Medicaid cuts, extensive
17 collaboration with Federation partners and other stakeholders, and ongoing policy, advocacy, and
18 technical assistance to the Federation of Medicine in an effort to mitigate the impact of these
19 changes on patients and physicians. (Note: Because of approval deadlines, this informational report
20 was prepared in February 2026 and does not include more recent developments. For more
21 information on the AMA’s up-to-date advocacy to mitigate or reverse the Medicaid cuts, please
22 visit www.ama-assn.org/OB3.)
23

24 BACKGROUND

25 *Summary of Medicaid Cuts*

26
27
28 The One Big Beautiful Bill Act of 2025 (Public Law 119-21 or OBBBA) enacted sweeping
29 changes to the Medicaid program and broader federal health care financing. The legislation reduced
30 federal Medicaid spending through a combination of structural financing changes, new eligibility
31 and administrative requirements, and limits on other long-standing program features. Collectively,
32 these provisions represent one of the most significant retrenchments of Medicaid funding in the
33 program’s history.

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

7
 8 The law’s rollback of provider tax arrangements has particular implications for state Medicaid
 9 programs, as these mechanisms have long been used, within federal parameters, to support states’
 10 share of Medicaid financing and stabilize physician and hospital payment rates. Reductions in
 11 provider tax authority may require states to reduce Medicaid expenditures, including eligibility,
 12 benefits, or provider payments, absent alternative revenue sources.

13
 14 In addition, the law authorizes Medicaid work requirements and requires more frequent eligibility
 15 verification processes, which introduce new administrative barriers for beneficiaries and state
 16 agencies. Past experience with similar policies has demonstrated a high risk of coverage loss
 17 among eligible individuals due to reporting burdens, confusion, and administrative churn. These
 18 provisions also increase administrative complexity for physicians and health care systems caring
 19 for patients on Medicaid.

20
 21 The law also established a new source of federal funding, the Rural Health Transformation
 22 Program, intended to offset impacts of reduced Medicaid spending in rural areas. However, the
 23 \$50 billion program is time limited and falls short of fully replacing lost funding from OBBBA. As
 24 a result, many states will still face significant challenges maintaining access to care, supporting
 25 physician practices, and sustaining safety-net health care infrastructure.

26
 27 *Impact and Response*

28
 29 Most of OBBBA’s changes have not taken effect yet and many of the law’s provisions will not
 30 become [effective](#) until 2027 or later. However, the law’s impacts on Medicaid are already being
 31 felt and states and other interested parties are responding:

- 32
 33 • **State responses to financing constraints.** If states are unable to continue financing their
 34 Medicaid programs at pre-OBBBA levels due to the loss of revenue from provider taxes
 35 and new restrictions on state-directed payments, they will be forced to make difficult
 36 budgetary decisions. As provider taxes and state-directed payments are frequently used to
 37 finance enhanced reimbursement rates or expansions in services, it is probable that states
 38 will respond by cutting provider rates or rolling back services, in addition to other cuts to
 39 state spending on Medicaid. In some states, Medicaid funding cuts have already been
 40 [announced](#) for 2026.
- 41 • **Patient impacts.** Major changes to Medicaid eligibility (work requirements and more
 42 frequent eligibility checks for certain adult beneficiaries, narrowing eligibility for legally
 43 present non-citizens) will take effect in the coming months. These changes, which present
 44 an extreme challenge for states to implement in a short timeframe, will disqualify many
 45 patients and could result in many more eligible patients [losing coverage](#) due to difficulties
 46 in navigating new procedures.
- 47 • **Provider impacts.** If, as expected, states reduce spending on Medicaid reimbursement
 48 rates and services and patients lose coverage, providers will be affected. Negative impacts
 49 will be felt most acutely in rural areas and other underserved communities where patients
 50 disproportionately rely on Medicaid. Some physician practices have already [reported](#)
 51 closures or consolidations in response to OBBBA’s cuts.

1 PUBLIC DENUNCIATION OF MEDICAID CUTS

2
 3 Immediately following congressional action of Public Law 119-21, the AMA publicly denounced
 4 the legislation’s Medicaid provisions through public statements and media engagements. On July 1,
 5 and July 3, 2025, the AMA issued national press statements following Senate and final
 6 congressional passage of the reconciliation bill, explicitly opposing the Medicaid and CHIP cuts
 7 and warning of coverage losses, cost shifting to states and providers, and harm to rural and
 8 underserved communities. AMA statements also underscored that reduced access to preventive and
 9 primary care would likely result in worsening health outcomes and higher long-term costs, as
 10 treatable conditions progress into more serious and costly illnesses. These statements were issued
 11 by AMA leadership and disseminated nationally through the AMA’s press and media channels.
 12

13 In addition, AMA published multiple AMA News Wire articles and policy analyses explaining the
 14 provisions of the law, outlining anticipated impacts on patients and physicians, and reinforcing the
 15 AMA’s longstanding position that Medicaid is a critical source of coverage for low-income
 16 patients and an essential component of the nation’s health care safety net.¹ Altogether, these actions
 17 constituted a clear, public denunciation of the Medicaid cuts enacted in OBBBA and
 18 communicated the AMA’s opposition to policymakers, physicians, and the public.
 19

20 In addition to press statements and media engagement, the AMA has developed and disseminated
 21 policy analyses, issue briefs, educational resources, and other advocacy materials regarding the
 22 Medicaid provisions of Public Law 119-21. As implementation proceeds, the AMA will continue
 23 to evaluate and deploy, as appropriate, the range of public-facing communications tools
 24 contemplated by Policy D-290.970, including formal position statements, opinion pieces, and other
 25 communications that elevate physician and patient concerns.
 26

27 ENGAGEMENT WITH STATE MEDICAL ASSOCIATIONS AND NATIONAL MEDICAL
 28 SPECIALTY SOCIETIES

29
 30 *Convening the Federation of Medicine*

31
 32 The AMA has served as a central convener for the Federation of Medicine to facilitate coordinated
 33 state responses to the Medicaid provisions of Public Law 119-21. Through regular national
 34 coordination calls, targeted small-group discussions, webinars, and active listservs, the AMA has
 35 connected state medical association and national medical specialty society government affairs
 36 leaders to share strategies, resources, and early insights into emerging implementation challenges.
 37 At the request of its Federation partners, the AMA created and maintains a centralized repository
 38 for advocacy materials, enabling medical association staff to exchange analyses, draft letters, and
 39 talking points and reduce the need for duplicative work. This convening role has strengthened
 40 cross-state collaboration and improved the ability of physician advocates across the country to
 41 anticipate and respond to policy developments affecting Medicaid financing and access to care.
 42

43 The AMA also convened multiple national webinars and briefing calls for state medical
 44 associations and national medical specialty societies focused on the Medicaid provisions in
 45 OBBBA. These sessions provided timely analysis of statutory changes, implementation timelines,
 46 and state-level decision points. Specifically, in August, the AMA convened state and specialty
 47 medical association staff at the AMA State Advocacy Roundtable for a focused discussion on
 48 approaches to implementing the law’s Medicaid provisions and identifying shared priorities across
 49 the Federation. During the fall, the AMA hosted two national calls for state medical associations
 50 and specialty societies on the Rural Health Transformation Program, with particular attention to its
 51 interaction with state scope of practice laws. The AMA also hosted a publicly available Advocacy

1 Insights webinar in November, attended by nearly 800 participants, which examined the effects of
2 the law on patients and physicians and identified key points of influence for the AMA and other
3 medical organizations. In December, the AMA conducted a Federation-wide webinar on Medicaid
4 provider taxes, examining the details of provider tax rollbacks and outlining state policy options to
5 mitigate funding losses. Additional briefings and educational sessions were held for state medical
6 association audiences, AMA Sections, and allied organizations. Medicaid policy and
7 implementation challenges were also a central focus of strategy discussions at the 2026 AMA State
8 Advocacy Summit, including engagement with Medicaid officials regarding state-level
9 implementation considerations.

10
11 *Development and Dissemination of Policy Tools and Resources*

12
13 In parallel with its convening efforts, the AMA has developed and disseminated a suite of policy
14 tools and expert resources to support state advocacy and implementation efforts. These include
15 issue briefs, policy summaries, and analyses addressing Medicaid work requirements, changes to
16 Medicaid financing, and modifications to eligibility and enrollment processes. The AMA also
17 produced detailed analyses, data tables, and slide decks to inform Rural Health Transformation
18 Program applications.

19
20 The AMA has also produced detailed toolkits for state and national medical specialty association
21 staff with specific recommendations for engaging lawmakers and Medicaid officials on medical
22 frailty exemptions and hardship exemptions. To ensure accuracy and credibility, the AMA has
23 engaged former Medicaid officials, tax experts, current state policymakers, think tanks, and
24 advocacy partners in the development of these materials and more. In addition to evolving our suite
25 of materials for our Federation partners, the AMA is in the process of producing communication
26 materials for physicians and patients to help explain upcoming Medicaid changes and coverage
27 risks, supporting continuity of care and informed patient decision-making.

28
29 *Individualized State-Level Technical Assistance*

30
31 Beyond broad-based education and advocacy, the AMA has provided individualized, one-on-one
32 consultation to state medical associations tailored to state-specific circumstances. This support has
33 included reviewing legislation, assessing options to mitigate impact of provider tax rollbacks,
34 advising on Medicaid work-requirement exemptions, and supporting engagement with state
35 legislatures and Medicaid agencies. In addition, the AMA provided extensive individualized
36 assistance, including state-specific funding estimations, to state medical associations as they
37 collaborated with state officials on Rural Health Transformation Program applications, particularly
38 as related to incentives in the program for state policymakers to expand scope of practice laws for
39 non-physician providers. Importantly, these efforts were highly successful, with only one-fifth of
40 states signaling intent to pursue scope of practice expansions in their program applications.

41
42 The AMA Advocacy Resource Center has also launched a new State Advocacy Accelerator Grant
43 Program to provide targeted, short-term funding to support high-priority state legislative or
44 regulatory campaigns. Grants, typically ranging from \$25,000 to \$50,000, are intended to support
45 discrete advocacy activities at critical moments, including contract lobbying, targeted
46 communications, physician grassroots engagement, coalition development, and rapid-response
47 research, and can be used to support Medicaid advocacy, as well as other issues.

1 COLLABORATION WITH STATE AND NATIONAL STAKEHOLDERS

2
3 The AMA has also actively engaged Medicaid officials, patient advocacy organizations, hospital
4 groups, safety-net providers, and policy experts to exchange information and track the real-world
5 impact of Medicaid cuts. Through webinars, coalition calls, and ongoing consultation, the AMA
6 has facilitated cross-sector dialogue on implementation challenges, mitigation strategies, and
7 opportunities for policy adjustments. This collaborative approach has supported more informed
8 advocacy and helped ensure that physician and patient perspectives are incorporated into ongoing
9 implementation discussions.

10
11 FEDERAL ADVOCACY AND REGULATORY ENGAGEMENT

12
13 In addition to the above, the AMA has engaged in robust advocacy efforts at the federal level.
14 During congressional consideration of Public Law 119-21, the AMA strongly opposed the
15 Medicaid cuts, among other policies, through vigorous lobbying, letters to the House and Senate,
16 and in public statements.

17
18 With OBBBA now law, the AMA has redirected its efforts towards advocating to federal
19 policymakers as they begin implementing OBBBA’s Medicaid provisions. The AMA is
20 particularly focused on the Centers for Medicare & Medicaid Services (CMS), the primary federal
21 agency responsible for overseeing Medicaid. The AMA has made recommendations to CMS
22 regarding the implementation of new restrictions on Medicaid provider taxes, the requirement that
23 certain beneficiaries verify their Medicaid eligibility on a more frequent, biannual basis, and the
24 requirement that states establish community engagement requirements (also known as “work
25 requirements”) for certain beneficiaries as a condition of Medicaid coverage. The AMA’s
26 recommendations to CMS include maximizing automatic, data-driven eligibility and renewal
27 processes that do not burden patients or physicians with administrative tasks, providing flexibility
28 and technical support to state Medicaid agencies, and communicating with states and interested
29 parties about OBBBA implementation in a timely, transparent, and thorough fashion. Through all
30 of these efforts, the AMA’s central aim is to ensure that OBBBA’s provisions are implemented in a
31 manner that minimizes harms to patients and disruptions to care.

32
33 Although opportunities for federal legislative action to reverse or mitigate OBBBA’s impacts are
34 limited, the AMA is encouraging Congress to provide strong oversight of OBBBA’s
35 implementation to ensure patient access is not compromised, support state flexibility and requests
36 for technical assistance, and monitor patient and provider impacts, especially in rural and safety net
37 settings.

38
39 ONGOING EFFORTS

40
41 The AMA’s work to reverse or mitigate Medicaid cuts is ongoing. The AMA continues to monitor
42 and inform federal and state implementation of Public Law 119-21, as well as provide coordinated,
43 operational support to state and specialty medical associations. This includes ongoing national and
44 issue-specific calls, targeted strategy meetings, and in-person convenings to support information-
45 sharing and coordinated advocacy on Medicaid eligibility and redeterminations, work
46 requirements, provider taxes and other financing issues, and the Rural Health Transformation
47 Program. These forums will continue to be used to identify emerging implementation issues, share
48 legislative and regulatory approaches, and elevate physician concerns to state and federal
49 policymakers to mitigate the harm of the enacted federal Medicaid cuts.

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

7 8 STRATEGIC PRIORITIES GOING FORWARD

9
10 As implementation of Public Law 119-21 proceeds, the AMA’s Medicaid advocacy strategy will
11 continue to operate on both federal and state tracks. Federal priorities include minimizing coverage
12 loss and administrative churn, maximizing automatic and data-driven renewal processes, protecting
13 patient access, preserving state flexibility, and ensuring strong federal oversight of implementation.
14 State priorities include supporting medical associations and physician advocates on provider taxes
15 and other financing issues, eligibility and redeterminations, work requirements, reimbursement and
16 access concerns, and the Rural Health Transformation Program. The AMA will pursue these
17 priorities through direct lobbying and regulatory engagement, public-facing communications,
18 coordinated convenings, one-on-one technical assistance, and development of advocacy resources
19 for state and specialty medical associations.

20 21 CONCLUSION

22
23 Through prompt public condemnation of Medicaid cuts, sustained collaboration with the
24 Federation and other stakeholders, and targeted advocacy efforts, the AMA has acted consistently
25 with the directives of Policy D-290.970. The Board of Trustees remains committed to opposing
26 policies that undermine Medicaid and to working with partners at all levels to protect patients,
27 physicians, and the health care safety net.

28 29 RECOMMENDATION

30
31 The Board of Trustees recommends that the fourth item of Policy D-290.970, “Call for Action by
32 the AMA to Reverse or Mitigate Medicaid Cuts,” be rescinded as having been accomplished by
33 this report and the remainder of the report be filed.

- 34
35 1. Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the “One Big
36 Beautiful Bill Act of 2025”);
37 2. Through, but not limited to, press releases, position statements, op-eds in major outlets,
38 press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates
39 to Medicaid;
40 3. Continue working with state medical societies, specialty societies, patient advocacy groups,
41 hospital systems and safety net organizations to advocate for the reversal or mitigation of
42 Medicaid-related cuts in Public Law 119-21;–
43 ~~4. Report back to the AMA’s House of Delegates at A-26. (Modify Current Policy)~~

Fiscal note: Less than \$500.

REFERENCES

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

REPORT 25 OF THE BOARD OF TRUSTEES (A-26)
Federal Legislation to Prohibit the Corporate Practice of Medicine
(Reference Committee B)

EXECUTIVE SUMMARY

Resolution 225, which was referred at the 2025 Interim Meeting, would support federal legislation banning the corporate practice of medicine (CPOM), provided it does not weaken existing state laws, and would seek to prohibit non-physician-owned entities from participating in federal health care payment programs.

The CPOM doctrine provides a legal framework to protect physicians from undue corporate influence in the delivery of health care. CPOM laws are variable and historically implemented at the state level, but a lack of enforcement activity combined with regulatory loopholes has limited the impact of state CPOM laws. However, there is momentum in state legislatures to reinvigorate the doctrine, and AMA supports state medical associations seeking to modernize CPOM legislation at the state level.

A federal CPOM prohibition is attractive insofar as it would clarify the doctrine and create a uniform set of baseline requirements, assuming that courts apply the doctrine of federal preemption to establish the desired federal floor. However, it is unclear whether a single uniform set of federal standards around CPOM would appropriately address the variable needs of each state. Moreover, the federal government may not be optimally equipped to enforce CPOM laws, whose violations tend to be granular and local in nature. Finally, the law's preemptive effect would be litigated, and it is difficult to predict what courts will find in the context of a particular state requirement. Absent statutory mechanisms that bolster enforcement, a federal CPOM bill could thereby result in ineffectual legislation that disrupts local health care markets, without the desired preemptive effect.

Banning non-physician-owned entities from participating in payment programs such as Medicare may disproportionately impact physicians over corporate owners, decrease access to care, and harm competition in health care markets. As a tool to increase leverage over violators of a CPOM prohibition, it creates a high degree of risk.

Ultimately, a categorical ban on CPOM is unlikely to achieve the intended effect without careful calibration. A more stable path for a federal CPOM prohibition might protect core elements of clinical independence and include specific, carefully crafted language reflecting the intent to preserve state flexibility to enact and enforce stricter requirements. This would likely limit federal preemption, which would protect physician autonomy without creating a rigid national standard around ownership structure that may be unevenly enforced or misaligned with local realities of care delivery. Additionally, a whistleblower program for violations of such a provision could strengthen enforcement efforts.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 25-A-26

Subject: Federal Legislation to Prohibit the Corporate Practice of Medicine
Resolution 225-I-25

Presented by: David Aizuss, MD, Chair

Referred to: Reference Committee B

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

5
6 RESOLVED, That our American Medical Association advocate for federal legislation that
7 prohibits lay corporations, including insurance companies, private equity firms, and other non-
8 physician-owned entities, from owning or controlling medical practices and healthcare
9 decision-making, and prohibits such entities from participation in federal healthcare payment
10 programs, in order to protect physician autonomy and strengthen the physician-patient
11 relationship (Directive to Take Action); and be it further

12
13 RESOLVED, That our AMA amend Policy H-215.981 – Corporate Practice of Medicine under
14 items #1 and #2 by addition and deletion as follows:

- 15
16 1. Our American Medical Association ~~vigorously opposes any effort to pass federal~~
17 ~~legislation or regulation preempting state laws~~ supports the passage of federal
18 legislation prohibiting the corporate practice of medicine.
19
20 2. Our American Medical Association vigorously opposes any effort to pass state or
21 federal legislation or regulation that removes or weakens existing state laws prohibiting
22 the corporate practice of medicine.
23

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

1 BACKGROUND

2
3 This section offers background on the CPOM doctrine and its implementation, considers legal and
4 practical implications of a federal CPOM ban, discusses the impact of provisions that would
5 prohibit non-physician-owned entities from participating in federal payment programs, and shares
6 how the AMA supports physicians in preventing corporate influence at the practice level.

7
8 *Corporate Involvement in Physician Practices*

9
10 Over the last two decades, corporations and private equity or hedge fund-backed entities have
11 increasingly entered health care delivery. The consumerization of health care has fostered
12 opportunities for corporations not traditionally involved in health care delivery to enter these
13 spaces, purporting to offer greater convenience at a lower cost.² Occurring alongside this trend is
14 the acquisition of independent physician practices by large corporations, hospitals, and payers.
15 According to one estimate, corporate entities acquired over 30,000 physician practices between
16 2019 and 2021.³

17
18 Some see corporate entry into health care as positive, believing it will make health care more
19 sustainable and grant physicians greater access to capital and the latest technology. In the optimal
20 scenario, private sector investment in physician practices may be helpful in providing
21 infrastructure. Owners of private practices increasingly seek to remain independent, and some have
22 argued that corporate investment can provide them with the agency and revenue to do so.⁴
23 However, accepting corporate investment does not necessarily mean that physicians must allow
24 corporations to own or influence their operations or clinical autonomy—it can be a transactional
25 financial arrangement.

26
27 Without guardrails, corporate investment may disrupt high-quality, coordinated care delivered by a
28 physician-led team, and many believe it decreases access and competition.⁵ Corporate investment
29 in health care is also thought to accelerate consolidation in medical specialties, which changes the
30 practice landscape for physicians and can drive down physician wages while increasing health care
31 costs for patients.⁶

32
33 In any case, when a corporate investor acquires a physician practice, the investor and the
34 physicians often have divided loyalties: physicians tend to value providing the highest quality care
35 and feel a deep sense of responsibility to their patients, while private equity firms and other
36 corporate investors, who are primarily accountable to shareholders and not patients, are likely to
37 pursue profit maximization. To this end, corporate investors may implement policies that prioritize
38 dividends at the expense of physician and patient interests. Physicians working in corporate-owned
39 practices note that corporate involvement can interfere with their ability to make decisions around
40 governance, care delivery, or practice operations. When there is a conflict between providing
41 appropriate care and the need for corporate investors for monetary return, not only can moral injury
42 result, but there also a potential conflict of interest for physicians that is exacerbated if the
43 corporation can terminate employment of the physician without cause. Accordingly, when a
44 corporate entity invests in a physician practice, there is a need to ensure that corporate influence
45 does not dictate decisions around care delivery and that physicians maintain not only clinical
46 autonomy but operational authority of their practices. Laws banning CPOM provide one such tool.

47
48 *The CPOM Doctrine*

49
50 The CPOM doctrine refers to a long-standing legal precept intended to preserve the independent
51 clinical judgment of physicians and safeguard patient care from undue corporate influence. At

1 present, CPOM laws are enacted, implemented, and enforced by states. While specific provisions
2 vary, CPOM laws generally limit the ability of lay (i.e., non-physician) corporations to intervene
3 with the practice of medicine or own physician practices. Broadly, CPOM restrictions aim to (1)
4 avoid the commercialization of medical practice that might result when corporations own practices
5 or perform activities that constitute the practice of medicine; (2) address any lack of alignment
6 between a corporation's obligation to its shareholders and a physician's obligation to their patients;
7 and (3) ensure that a physician's exercise of independent medical judgment is not threatened
8 because they are employed by a corporate entity.

9
10 Specific provisions in a CPOM law may include rules to protect a physician's independent exercise
11 of clinical decision-making, practice ownership restrictions which may include requirements
12 around how many shareholders or directors must be physicians, requirements around what entities
13 may employ physicians, bans on fee-splitting arrangements, provisions around auditing and
14 enforcement, and a range of exemptions. More recently, novel provisions have emerged in state
15 legislatures that impose requirements on the structural relationship between a physician practice
16 and a management services organization (MSO).⁷

17 18 *Regulation of CPOM*

19
20 States have long regulated the practice of medicine in light of local needs and in the context of state
21 health care markets—in many states, CPOM laws date back centuries. The CPOM doctrine in each
22 state has evolved over time, not only through legislation but also through judicial decisions,
23 Attorney General opinions, and medical board policy. As a result, there is variation in how the
24 doctrine has developed across the country. For example, while some states simply ban the
25 unlicensed practice of medicine, others broadly prohibit all corporate entities from employing
26 physicians, and still others have specific rules around what constitutes a permissible ownership
27 structure for a medical practice.⁸ Exceptions to CPOM bans also vary, with many states allowing
28 hospitals, health maintenance organizations, or other entities to employ physicians.

29
30 Scholars have questioned the impact and effectiveness of the CPOM doctrine as it currently
31 stands,⁹ with two primary factors driving this skepticism. First, enforcement of CPOM bans is
32 functionally dormant in many states. Second, CPOM laws often leave room for structural
33 workarounds that enable corporations to influence the practice of medicine, most commonly
34 through MSOs, often in combination with a “friendly physician” who may facilitate corporate
35 influence over care delivery.¹⁰

36
37 A handful of states do have enforcement mechanisms for CPOM prohibitions in place. Still, there
38 is room to modernize and strengthen state corporate practice restrictions, and recent growth in
39 corporate investment in health care has spurred a renewed groundswell of interest in the potential
40 of CPOM prohibitions, prompting state legislative action in this area. About a dozen bills
41 implicating CPOM were introduced in state legislatures last year, with Oregon and California
42 enacting particularly notable legislation.¹¹ Notably, several bills have also been introduced for
43 consideration during the 2026 legislative session.¹²

44
45 Frequently, these state bills aim to strengthen CPOM provisions by setting discrete parameters for
46 what constitutes corporate interference with medical practice and clearly establishing oversight.
47 Many would also implement provisions to address the MSO loophole, for example by requiring
48 that physicians who contract with an MSO retain meaningful control over clinical decisions or
49 prohibiting certain types of dual affiliation between the leadership of an MSO and a practice with
50 which the MSO contracts. Indeed, both California and Oregon recently enacted legislation that
51 limits MSOs from controlling physicians' clinical or operational decisions, and novel provisions in

1 Oregon’s bill impose requirements that erode “friendly physician” arrangements.¹³ Related state
 2 legislation, including bills in Massachusetts and California,¹⁴ among other states, would promote
 3 transparency around corporate involvement in health care by authorizing designated state agencies
 4 to review or approve health care transactions involving corporate entities—these bills bolster
 5 existing CPOM bans by shining light on transactions that may pose a threat to physician autonomy
 6 and providing a clear basis for the exercise of state enforcement authority.

7
 8 The CPOM doctrine has not reached its full potential in the states, but state CPOM laws provide a
 9 long-standing legal framework to protect the practice of medicine from undue corporate influence
 10 in a manner that is responsive to the specific needs that arise in local health care markets. The
 11 AMA tracks state legislation that would restrict the corporate practice of medicine and provides
 12 support and resources to state medical associations aiming to limit corporate influence on the
 13 delivery of care.¹⁵

14
 15 *The Option for a Federal CPOM Ban*

16
 17 Those enthusiastic about a federal approach posit that a uniform set of federal CPOM requirements
 18 would bring clarity to the doctrine, provide an opportunity to create a strong baseline prohibition
 19 that would override weaker state laws (i.e., establish a “federal floor”), and reinvigorate
 20 enforcement of CPOM bans. However, questions surrounding the practical and legal considerations
 21 of a federal ban prompted the referral of Resolution 225-I-25 and required review.

22
 23 A One-Size-Fits-All Standard

24
 25 A federal CPOM ban would establish a single, easily understood law nationwide, which would
 26 consolidate the doctrine and reduce legal complexity. However, uniformity risks destabilizing
 27 health care markets. Because variations in state laws governing CPOM reflect the unique
 28 characteristics of local health care economies, a single federal CPOM standard is unlikely to
 29 address the specific needs of physicians in every state. Pursuit of a workable standard would
 30 require careful, nuanced distinctions between arrangements that support physician autonomy and
 31 those that factually undermine it, which may prove more aspirational than practical. A federal rule
 32 risks interference with existing state-tailored solutions, potentially harming physician autonomy,
 33 patient access to care, and the stability of health care markets that have evolved to meet local
 34 needs.

35
 36 The risk of destabilizing health care practices and the markets in which they operate would be
 37 especially pronounced should federal law displace state laws that impose requirements around
 38 ownership structures for physician practices or around the relationship between physician practices
 39 and MSOs. Some states strictly limit practice ownership to physicians, while others allow more
 40 flexibility, such as majority physician shareholders or carefully regulated, but variable, MSO
 41 structures. These and their related exceptions reflect deeply rooted local practices and regulatory
 42 approaches. If a federal ban were to impose a one-size-fits-all standard, it could render existing
 43 practice arrangements unlawful, possibly undermining some practices and requiring a degree of
 44 unwinding.¹⁶ Thus, should a federal standard be imposed, there may need to be a transition period
 45 to allow unentangling of practice agreements. Even still, the impact of federal CPOM policy,
 46 especially where it implicates practice structure, is likely to be felt unevenly across states,
 47 disrupting some markets more dramatically than others.

Federal Preemption

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

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

The preemption analysis is fact-specific and interpretively complex, making it difficult to predict.²¹ Complicating this, once a bill is introduced in Congress, large scale amendments are often made, some of which fundamentally change the nature of the original text. The likelihood of state authority being preserved increases if the final federal statute includes an explicit clause permitting stricter state laws, but the actual preemptive effect will depend on judicial interpretation of specific statutory provisions and the extent to which Congress intended to occupy the field or restrict supplemental state regulations. The floor envisioned by Resolution 225-I-25 is certainly possible with careful drafting; however, it is also possible that a federal CPOM ban could result in state laws being preempted and replaced with a federal standard that may be less protective than existing requirements.

Federal Enforcement of a CPOM Ban

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

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

12
13 Federal enforcement of a CPOM ban may not be similarly robust. The federal government has
14 failed to strongly enforce laws that impose a broad substantive mandate similar to the restriction of
15 corporate control over clinical decision-making.²⁵ Regulators enforcing a CPOM ban must detect
16 non-quantitative violations within complex contractual and financial arrangements—enforcement
17 demands examination of management services agreements, equity structures, compensation
18 models, and de facto control rights. Unlike fraud and abuse violations, CPOM violations are not
19 connected to a federal payment program. Finally, enforcing CPOM bans is challenging because
20 violations are difficult to detect. Data analytics will not expose CPOM violations, which are
21 qualitative in nature, and most transactions that raise CPOM concerns (e.g., the acquisition of a
22 medical practice by private equity) fall well below the threshold that triggers review under federal
23 antitrust laws.²⁶

24
25 All this notwithstanding, a whistleblower program has the potential to increase visibility and
26 therefore enforcement of CPOM violations and create a threat of exposure that may provide
27 meaningful incentive for compliance. For example, the DOJ implemented a whistleblower program
28 for antitrust violations in 2024 that specifically targets health care enforcement.²⁷ It is modeled
29 after a program implemented by the Securities Exchange Commission which has significantly
30 increased enforcement of anti-retaliation laws.²⁸ A similar program may be feasible here.

31 32 *Banning Non-Physician-Owned Entities from Participating in Federal Payment Programs*

33
34 Resolution 225-I-25 seeks policy banning all non-physician entities—which may include hospitals
35 and integrated health systems in addition to many private-equity backed groups and other corporate
36 investors—from participating in federal health care payment programs like Medicare. The Board of
37 Trustees (the Board) infers that the intent behind this proposal is to add leverage to enforcement of
38 CPOM provisions, given precedent set by the Anti-Kickback Statutes, which grant the Office of the
39 Inspector General (OIG) authority to bar individuals found guilty of violating the statute from
40 participating in Medicare and state health care payment programs.²⁹

41
42 In the context of CPOM, the Board notes that this policy would have significant and probably
43 unintended consequences. Conditioning Medicare payment on CPOM compliance could suspend
44 Medicare billing for an entire practice; however, depending on the practice agreement it is possible
45 that it would disproportionately punish physicians over corporate owners. Where physician
46 payment arrangements are based on Relative Value Unit or salary/bonus models, physicians may
47 be shielded and the corporate entity would be penalized. However, Medicare privileges generally
48 sit with the individual physician, not the upstream practice owners, thus targeting financial
49 penalties would be preferable to Medicare participation/privilege. Thus, this policy could disrupt
50 physician income streams while penalizing clinicians who may not control or even have clear

1 knowledge of their practice’s specific ownership structure or the details of any agreements in place
 2 that may violate CPOM provisions.

3
 4 Finally, lack of clarity around what constitutes “ownership” would need to be addressed as state
 5 laws vary widely—once this is done, the consequences described here may be disproportionately
 6 severe in some states. As previously debated in the HOD, the litmus test could be operational
 7 authority at the most basic level.

8
 9 While in theory, conditioning Medicare participation on CPOM compliance would create leverage
 10 for enforcers, it also risks harm to physicians and patients, uneven enforcement, and destabilization
 11 of practice infrastructure. In addition, the Board is concerned that proposing a broad-stroke federal
 12 CPOM prohibition may have some risk of unintended consequences, especially of jeopardizing
 13 existing state regulations and laws that may be stricter than what can be realistically passed
 14 federally. Thus, any proposal would need to account for a phase-in period and the need for
 15 carefully calibrated policies that address the concern of preemption and appropriately targeted
 16 penalties.

17
 18 *AMA’s Support of Private Practice Physicians*

19
 20 While legislation provides one avenue for protecting physicians from corporate influence in their
 21 practice, and AMA actively supports states seeking to enact strong CPOM laws, action can also be
 22 taken at the practice level, for example in careful contracting with any corporate partners. Because
 23 many corporate investments in independent practice have not been positive, the AMA has offered
 24 guidance to assist physicians with required due diligence in any contractual arrangement with
 25 private equity firms, venture capital, and hedge funds.

26
 27 The High-Performing Private Practice Initiative (the Initiative) was launched in 2021 to enhance
 28 the AMA’s efforts to address a concerning downward trend in physician practice ownership. The
 29 Initiative created essential resources to support private practice. Between 2021 and 2022, the
 30 Initiative developed the Private Practice Web Toolkit, the Simple Solutions educational series, the
 31 Thriving in Private Practice podcast, and the Private Practice Playbook v1.0. Further, the
 32 Navigating Practice program introduced medical students to independent practice as a viable career
 33 path. By 2023-2024, programming expanded with the STEPS Forward® Attending to Business
 34 podcast and an updated Private Practice Playbook v2.0. The June 2024 Business of Medicine
 35 Workshop represented a pivotal evolution from passive resources to active business education.
 36 Resources to support physician practices in matters related to CPOM include a series on venture
 37 capital and private equity investment, one component of which is a contracting toolkit for
 38 physicians entering arrangements with corporate investors.³⁰

39
 40 Notably, in the fall of 2026, the AMA will launch the Independent Practice Accelerator—a two-
 41 day intensive workshop distilling essential competencies through expert sessions, case studies, and
 42 peer networking. This accessible format will provide physicians exploring or beginning
 43 independent practice with foundational knowledge in strategic planning, obtaining capital, business
 44 fundamentals, revenue cycle management, operations, leadership, and marketing. By preserving
 45 physician choice and practice model diversity, the program advances the AMA’s core mission of
 46 removing obstacles to patient care and ensuring high-quality care delivery.

47
 48 **DISCUSSION**

49
 50 Well-founded concerns about erosion of clinical autonomy underscore the desire for a federal
 51 CPOM prohibition that creates a uniform federal standard upon which state law may build.

1 However, a categorical ban on CPOM is unlikely to achieve the intended effect without careful
2 calibration, because uniform structural requirements around physician ownership could require the
3 unwinding of existing physician practice arrangements that may be working. However, if it is
4 working, it is possible that an arrangement would still work under an appropriately tailored CPOM
5 law that would be beneficial to both parties. Further, broad substantive requirements are difficult
6 for federal agencies to enforce, and a federal prohibition raises preemption concerns. In addition,
7 conditioning participation in federal health care payment programs on CPOM compliance would
8 have consequences that disproportionately impact physicians and patients rather than corporate
9 owners. Existing AMA policy opposes the corporate practice of medicine and tends to support
10 AMA engagement on this issue.

11 12 AMA POLICY

13
14 Current AMA policy opposes the corporate practice of medicine as well as efforts to weaken or
15 remove existing laws or regulations prohibiting CPOM, acknowledging that the corporate practice
16 of medicine can erode the patient-physician relationship. It offers guidance to physicians seeking
17 relationships with corporate entities, including examples of activities that constitute clinical
18 decisions that must remain under the control of the physician.

19
20 AMA Policy H-215.981, "[Corporate Practice of Medicine](#)" states that:

- 21 1. Our AMA vigorously opposes any effort to pass federal legislation or regulation
22 preempting state laws prohibiting the corporate practice of medicine.
- 23 2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or
24 weakens state laws prohibiting the corporate practice of medicine.
- 25 3. Our AMA opposes the corporate practice of medicine and supports the restriction of
26 ownership and operational authority of physician medical practices to physicians or
27 physician-owned groups.
- 28 4. Our AMA, at the request of state medical associations, will provide guidance, consultation,
29 and model legislation regarding the corporate practice of medicine, to ensure the autonomy
30 of hospital medical staffs, employed physicians in non-hospital settings, and physicians
31 contracting with corporately owned management service organizations.
- 32 5. Our AMA will continue to monitor the evolving corporate practice of medicine with
33 respect to its effect on the patient-physician relationship, financial conflicts of interest,
34 patient centered care and other relevant issues.
- 35 6. Our AMA will work with interested state medical associations, the federal government,
36 and other interested parties to develop and advocate for regulations and appropriate
37 legislation pertaining to corporate control of practices in the healthcare sector such that
38 physician clinical autonomy and operational authority are preserved and protected.
- 39 7. Our AMA will create a state corporate practice of medicine template to assist state medical
40 associations and national medical specialty societies as they navigate the intricacies of
41 corporate investment in physician practices and health care generally at the state level and
42 develop the most effective means of prohibiting the corporate practice of medicine in ways
43 that are not detrimental to the sustainability of physician practices.
- 44 8. Our AMA supports enforcement of existing regulations and legislation pertaining to
45 corporate control of practices in the health care sector to ensure that physician clinical
46 autonomy and operational authority is preserved and protected.
- 47 9. Our AMA supports capital reserve requirements and leverage standards that preserve
48 access to care for patients and fulfillment of contractual obligations to physicians and
49 trainees by providing stable financing for hospitals, clinics, and other health care facilities.

1 Policy H-160.887, "[Corporate Practice of Medicine](#)," acknowledges that the corporate practice of
2 medicine has the potential to erode the patient-physician relationship and may create a conflict of
3 interest between profit and best practices in residency and fellowship training.
4

5 Policy H-160.891, "[Corporate Investors and Other Corporate Entities](#)," offers the following
6 guidelines for physicians contemplating corporate entity relationships:

- 7 1. Our AMA encourages physicians who are contemplating corporate investor partnerships or
8 corporate entity relationships, including those under "friendly" physician professional
9 corporation (PC) arrangements with Management Service Organizations (MSOs), to
10 consider the following guidelines:
 - 11 a. Physicians should consider how the practice's current mission, vision, and long-term
12 goals align with those of the corporate investor/entity.
 - 13 b. Due diligence should be conducted that includes, at minimum, review of the corporate
14 investor/entity's business model, strategic plan, leadership and governance, and
15 culture.
 - 16 c. External legal, accounting and/or business counsels should be obtained to advise
17 during the exploration and negotiation of corporate investor/entity transactions.
 - 18 d. Retaining negotiators to advocate for best interests of the practice and its employees
19 should be considered.
 - 20 e. Physicians should consider whether and how corporate relationships may require
21 physicians to cede varying degrees of control over practice decision-making and day-
22 to-day management.
 - 23 f. Physicians should consider the potential impact of corporate relationships on physician
24 and practice employee satisfaction and future physician recruitment.
 - 25 g. Physicians should have a clear understanding of compensation agreements,
26 mechanisms for conflict resolution, processes for exiting corporate relationships, and
27 application of restrictive covenants, including any changes in the scope or
28 implementation of any current or proposed restrictive covenants based on the corporate
29 relationship.
 - 30 h. Physicians should consider corporate procedures for medical staff representation on the
31 board of directors and medical staff leadership selection as well as processes for
32 resolution of conflict between medical staff leadership and the corporate entity.
 - 33 i. Physicians should retain responsibility for clinical governance, patient welfare and
34 outcomes, physician clinical autonomy, and physician due process under corporate
35 relationships.
 - 36 j. Prior to entering into a relationship with a corporate entity, physicians and the
37 corporate entity should explicitly identify the types of clinical and business decisions
38 that should remain in the ultimate control of the physician, including but not limited to:
 - 39 i. Determining which diagnostic tests are appropriate;
 - 40 ii. Determining the need for referrals to, or consultation with another physician or
41 licensed health professional;
 - 42 iii. Being responsible for the ultimate overall care of the patient, including
43 treatment options available to the patient;
 - 44 iv. Determining how many patients a physician shall see in a given period of time
45 or how many hours a physician should work;
 - 46 v. Determining the content of patient medical records;
 - 47 vi. Selecting, hiring, or firing physicians, other licensed health care professionals,
48 and/or other medical staff based on clinical competency or proficiency;
 - 49 vii. Setting the parameters under which a physician or physician practice shall
50 enter into contractual relationships with third-party entities;

- 1 viii. Making decisions regarding coding and billing procedures for patient care
- 2 services; and
- 3 ix. Approving the selection of medical equipment and medical supplies.
- 4 k. Each individual physician should have the ultimate decision for medical judgment in
- 5 patient care and medical care processes, including supervision of non- physician
- 6 practitioners.
- 7 l. Clear protection and dispute resolution processes for physicians advocating on patient
- 8 care and quality issues should be incorporated into an agreement between physicians
- 9 and corporate entities.
- 10 m. Physicians should retain primary and final responsibility for structured medical
- 11 education inclusive of undergraduate medical education including the structure of the
- 12 program, program curriculum, selection of faculty and trainees, as well as education
- 13 and disciplinary issues related to these programs.
- 14 2. Our AMA supports improved transparency regarding corporate investments in and/or
- 15 relationships to physician practices, subsidiaries and/or related organizations that interact
- 16 with the physician group and/or patients of the physicians, and subsequent changes in
- 17 health care prices, quality, access, utilization, and physician payment.
- 18 3. Our AMA encourages national medical specialty societies to research and develop tools
- 19 and resources on the impact of corporate investor relationships on patients and the
- 20 physicians in practicing in that specialty.
- 21 4. Our AMA supports consideration of options for gathering information on the impact of
- 22 private equity and corporate investors/entities on the practice of medicine.
- 23 5. Our AMA supports meaningful physician representation in any corporate governance
- 24 structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of
- 25 any entity with which a physician practice, hospital, or other health care organization
- 26 establishes a corporate relationship.

27 28 CONCLUSION

29
30 The Board understands the urgency with which corporate intrusion on the practice of medicine
31 needs to be addressed, and appreciates that at present, state enforcement of CPOM bans is largely
32 lacking. At the same time, we acknowledge certain risks and limitations associated with a federal
33 approach. However, given the importance of this issue, we support the notion that the AMA should
34 take an active stance against corporate intrusion on the delivery of care at both the state and federal
35 level. A more stable path for federal engagement on CPOM might pursue a narrowly tailored
36 federal law to protect core elements of clinical independence, and craft it carefully to include
37 language reflecting an intent to preserve state authority to enact and enforce related and more
38 stringent laws. Especially if associated with a whistleblower program to add leverage to federal
39 enforcement activity, this model would protect physician autonomy without risking destabilization
40 of state health care markets, while leaving room for states to implement and enforce related
41 provisions.

42 43 RECOMMENDATIONS

44
45 The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the
46 remainder of this report be filed:

- 47
- 48 1. That the American Medical Association, in order to protect physician autonomy and
- 49 strengthen the physician-patient relationship, support federal legislation prohibiting lay
- 50 entities, including but not limited to insurance companies, private equity firms, non-
- 51 physician individual licensed health care professionals and other non-physician-owned

1 entities or individuals, from interfering with, controlling, or otherwise directing 1) the
2 independent professional judgment or clinical decisions of a physician, or 2) the
3 operational authority of physicians within their practices, provided that any such legislation
4 include a specific saving clause clarifying an intent to preserve the right of states to enact
5 and enforce more stringent state laws. (New HOD Policy)
6

7 2. That the AMA support whistleblower programs that allow individuals to report knowledge
8 of violations of a law prohibiting lay entities from interfering with, controlling, or
9 otherwise directing the professional judgment, clinical decisions, or operational authority
10 of a physician to the appropriate enforcement agency. (New HOD Policy)
11

12 3. That the AMA support the implementation and enforcement of strong state laws or
13 regulations that prohibit the corporate practice of medicine (New HOD Policy)
14

15 4. That Policy H-215.981, "Corporate Practice of Medicine," be amended by addition and
16 deletion as follows:
17

18 ~~1. Our American Medical Association vigorously opposes any effort to pass federal~~
19 ~~legislation or regulation preempting state laws prohibiting the corporate practice of~~
20 ~~medicine.~~

21 1.2. Our AMA vigorously opposes any effort to pass legislation or regulation that
22 removes or weakens state or federal laws prohibiting the corporate practice of
23 medicine.

24 2.3. Our AMA opposes the corporate practice of medicine and supports the restriction
25 of ownership and operational authority of physician medical practices to
26 physicians or physician-owned groups.

27 3. Our AMA, at the request of state medical associations, will provide guidance,
28 consultation, and model legislation regarding the corporate practice of medicine, to
29 ensure the autonomy of hospital medical staffs, employed physicians in non-
30 hospital settings, and physicians contracting with corporately owned management
31 service organizations.

32 4.5. Our AMA will continue to monitor the evolving corporate practice of medicine
33 with respect to its effect on the patient-physician relationship, financial conflicts of
34 interest, patient centered care and other relevant issues.

35 5.6. Our AMA will work with interested state medical associations, the federal
36 government, and other interested parties to develop and advocate for regulations
37 and appropriate legislation pertaining to corporate control of practices in the health
38 care sector such that physician clinical autonomy and operational authority are
39 preserved and protected.

40 6.7. Our AMA will create a state corporate practice of medicine template to assist state
41 medical associations and national medical specialty societies as they navigate the
42 intricacies of corporate investment in physician practices and health care generally
43 at the state level and develop the most effective means of prohibiting the corporate
44 practice of medicine in ways that are not detrimental to the sustainability of
45 physician practices.

46 7.8. Our AMA supports enforcement of existing regulations and legislation pertaining
47 to corporate control of practices in the health care sector to ensure that physician
48 clinical autonomy and operational authority is preserved and protected.

49 8.9. Our AMA supports capital reserve requirements and leverage standards that
50 preserve access to care for patients and fulfillment of contractual obligations to

- 1 physicians and trainees by providing stable financing for hospitals, clinics, and
- 2 other health care facilities. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

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- ² See, e.g., CB Insights. The Big Tech In Healthcare Report: How Facebook, Apple, Microsoft, Google, & Amazon Are Battling For The \$8.3T Market. Published November 30, 2021. <https://www.cbinsights.com/research/report/famga-big-tech-healthcare/>
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- ⁷ See, e.g., OR SB 951 (2025), amended by OR HB 3410 (2025). 83rd OREGON LEGISLATIVE ASSEMBLY--2025 Regular Session
- ⁸ Dilani Logan and Katherine L. Gudiksen. The Source on Healthcare Price & Competition. The Corporate Practice of Medicine: Time for a Reevaluation? March 2025. Available at: <https://sourceonhealthcare.org/wp-content/uploads/2025/03/The-Source-Corporate-Practice-of-Medicine-02.pdf>
- ⁹ Zhu, J M.D., M.P.P., M.S.H.P. <https://orcid.org/0000-0002-4868-6078>, Hayden Rooke-Ley, J.D., and Erin Fuse Brown, E J.D., M.P.H. A Doctrine in Name Only—Strengthening Prohibitions Against the Corporate Practice of Medicine. N Engl J Med 2023;389:965-968. Published September 9, 2023.
- ¹⁰ Id.
- ¹¹ OR SB 951 (2025), amended by OR HB 3410 (2025); See also CA SB 351 (2025)
- ¹² Among the states where legislation related to CPOM has been introduced are Connecticut, Rhode Island, New Jersey, Maine, and New Mexico.
- ¹³ *Supra* note 11.
- ¹⁴ MA HB 5159 (2025) and CA SB 351 (2025)
- ¹⁵ See, e.g. American Medical Association, Advocacy Resource Center. Legislative approaches to curb corporate influence in health care: State-level policy options to protect the integrity of medical practice amidst increased investment in health care by private equity firms and other corporate entities. <https://www.ama-assn.org/system/files/state-leg-approaches-to-curb-corporate-influence-in-health-care.pdf>
- ¹⁶ To indicate, state bills such as CA SB 351 (2025) prohibited certain agreements between MSOs and physician practices (PC) and implemented strong enforcement measures, prompting the restructuring of non-compliant arrangements. See, e.g., Carsonie F, et al. Benesch. California Enacts SB 351: New Restrictions on Private Equity and Hedge Fund Involvement in Physician and Dental Practices. October 14, 2025. <https://www.beneschlaw.com/insight/california-enacts-sb-351-new-restrictions-on-private-equity-and-hedge-fund-involvement-in-physician-and-dental-practices/>
- ¹⁷ See Adkins, Bryan L.; Pepper, Alexander H.; Sykes, Jay B. Federal Preemption: A Legal Primer. Congressional Research Service Report Number R45825. Updated May 18, 2023. Available at <https://www.congress.gov/crs-product/R45825>.
- ¹⁸ *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 120 S. Ct. 1913
- ¹⁹ *Supra* note 17.
- ²⁰ See, e.g., the preemptive language in the HIPAA regulations. 45 C.F.R. § 160.201 *et. seq.*
- ²¹ *Supra* note 17.
- ²² See, e.g., U.S. Department of Justice. National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over \$14.6 Billion in Alleged Fraud. Published June 30, 2025.
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²⁶ As of February 2026, the valuation threshold for reportability under the Hart-Scott-Rodino Act is \$133.9 million. U.S. Federal Trade Commission. New HSR thresholds and filing fees for 2026. Published January 20, 2026. Available at: <https://www.ftc.gov/enforcement/competition-matters/2026/01/new-hsr-thresholds-filing-fees-2026>

²⁷ U.S. Department of Justice. Corporate Whistleblower Awards Pilot Program. Revised May 12, 2025. Available at: <https://www.justice.gov/criminal/media/1400041/dl?inline>.

²⁸ U.S. Securities Exchange Commission. Office of the Whistleblower. Annual Report to Congress for Fiscal Year 2025. February 11, 2026. Available at: <https://www.sec.gov/files/fy25-annual-whistleblower-report.pdf>.

²⁹ 42 U.S.C. 1320a-7(b)(7)

³⁰ *See, e.g.* American Medical Association. Venture Capital and private equity investment – Snapshot. Available at: <https://www.ama-assn.org/system/files/2019-07/investment-snapshot.pdf>. *See also* American Medical Association. Venture capital and private equity investment: How to evaluate contractual agreements. Available at: <https://www.ama-assn.org/system/files/2019-07/evaluate-contractual-arrangements.pdf>.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 27-A-26

Subject: Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS (Res. 819-I-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

1 At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD), Resolution 819, “Update the Status of Virtual Credit Card Policy, Electronic Funds
3 Transfer (EFT) Fees, and Lack of Enforcement of Administrative Simplification Requirements by
4 the Centers for Medicare & Medicaid Services (CMS),” was adopted as amended and became
5 Policy D-190.965. It asked the following:

6
7 Our American Medical Association report at the Annual 2026 Meeting on the progress of, and
8 action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968.
9 (Directive to Take Action)

10
11 Testimony before the Reference Committee was limited but uniformly supportive. Delegates
12 expressed continued concern that, despite sustained AMA advocacy, the financial burden
13 associated with virtual credit card (VCC) payments and EFT processing fees persists and, in some
14 cases, has intensified. Testimony highlighted the cumulative impact of these fees on physician
15 practices, particularly small and rural practices operating on narrow margins. An amendment was
16 offered to require that the progress report be delivered one year earlier than originally proposed and
17 to specify that the report include concrete “action items” outlining the AMA’s regulatory and
18 legislative strategy. Delegates emphasized the urgency of the issue and the need for visible
19 enforcement of existing Administrative Simplification requirements by CMS. The Reference
20 Committee recommended adoption of the resolution as amended, and the House concurred.

21
22 **BACKGROUND**

23
24 To reduce paperwork and streamline business processes across the health care system, the Health
25 Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent policies adopted
26 certain national standard transactions for the electronic exchange of health care data. These
27 transactions included EFT payments and electronic remittance advice. Beginning in the early
28 2000s, health plans began transitioning from issuing paper checks to using electronic payment
29 methods for physicians.

30
31 This shift was significantly accelerated by the Patient Protection and Affordable Care Act (ACA)
32 of 2010, which included provisions aimed at increasing administrative efficiency, notably the
33 establishment of a standard for EFT. Under this requirement, health plans had to offer physician
34 practices the option to receive payments via the Automated Clearing House (ACH) Network.
35 Health plans may use clearinghouses and other vendors to meet their obligation to offer standard

1 electronic transactions. Health plans and their vendors have sought alternatives to the ACH EFT
2 standard since its adoption, which compete with and deter adoption of electronic transactions as
3 envisioned by the ACA. Health plans or their vendors have leveraged flexibility in the EFT final
4 rule, which permits nonstandard electronic payments using VCCs. VCCs are often promoted as the
5 easiest and quickest form of payment, despite significant processing fees. Alternatively, plans or
6 their vendors force physicians to accept additional “value-added services” and associated
7 percentage-based fees with EFT payments. The fees that health plans and their vendors charge
8 practices for simply receiving electronic payments create significant administrative burdens and
9 divert funds that could otherwise support patient care.

10
11 Challenges around electronic transactions from health plans and clearinghouses were further
12 exacerbated by the Change Healthcare cyberattack in February 2024 and the subsequent service
13 outage. The Board of Trustees is well aware of the financial and administrative burdens that this
14 unprecedented cyber event placed on physician practices and patients nationwide. The AMA was
15 actively engaged with Optum and Change Healthcare to address ongoing issues related to the
16 disruption and requested increased flexibility in the recoupment of payments on loans to practices,
17 as well as in meeting timely claim-filing deadlines for the period when Change Healthcare’s
18 systems were non-functional, and practices were unable to file claims.

19
20 Unfortunately, the cyberattack and outage also compromised existing electronic transaction
21 enrollments with vendors and clearinghouses, requiring re-enrollment to protect patient and
22 physician data. Issues with the timing, costs, and other obstacles facing practices in re-enrolling to
23 receive electronic transactions, such as EFT, hampered the recovery from the cyberattack. When
24 EFT enrollments expired, many health plans and their vendors did not contact physician practices
25 in advance to facilitate swift re-enrollment; instead, they automatically defaulted to VCC or fee-
26 based EFT payments. Overall, the cyberattack and its aftermath only compounded the challenges
27 and burdens that physician practices have long faced with electronic transaction fees.

28 29 AMA POLICY

30
31 The AMA has longstanding policy on VCCs and EFT electronic processing fees. First, the Board
32 of Trustees notes three policies that are particularly relevant to the discussion that focus on
33 increasing education around the use of VCCs in physician practices, as well as advocacy that
34 promotes advance disclosure by payers of transaction fees and physician access to no-fee EFT
35 options as an alternative to VCCs:

36 37 Policy H-190.955, “Virtual Credit Card Payments”

- 38
39
- 40 1. Our American Medical Association will educate its members about the use of virtual credit
41 cards by third party payers, including the costs of accepting virtual credit card payments
42 from third party payers, the beneficiaries of the administrative fees paid by the physician
43 practice inherent in accepting such payments and the lower cost alternative of electronic
44 funds transfer via the Automated Clearing House.
 - 45 2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees
46 associated with virtual credit cards and any rebates or other incentives awarded to payers
47 for utilizing virtual credit cards.
 - 48 3. Our AMA supports transparency, fairness, and provider choice in payers’ use of virtual
49 credit card payments, including: advanced physician consent to acceptance of this form of
50 payment; disclosure of transaction fees; clear information about how the provider can opt
51 out of this payment method at any time; and prohibition of payer contracts requiring
acceptance of virtual credit card payments for network inclusion.

1 Policy D-190.970, “CMS Administrative Requirements”

- 2
- 3 1. Our American Medical Association will forcefully advocate that the Centers for Medicare
- 4 and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative
- 5 simplification requirements thoroughly and offers transparency in its processes and
- 6 decisions as required by the Administrative Procedure Act (APA).
- 7 2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-
- 8 compliant payment methods including opt-out virtual credit cards, charging processing fees
- 9 for electronic claims and other illegal electronic funds transfer (EFT) fees.
- 10 3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of
- 11 Burden Reduction to effectively enforce the HIPAA administrative simplification
- 12 requirements as required by the law and its failure to impose financial penalties for non-
- 13 compliance by health plans.
- 14 4. Our AMA will through legislation, regulation or other appropriate means, advocate for the
- 15 prohibition of health insurers charging physicians and other providers to process claims
- 16 and make payment.
- 17

18 Policy D-190.968, “Amend Virtual Credit Card and Electronic Funds Transfer Fee”

- 19
- 20 1. Our American Medical Association will advocate for legislation or regulation that would
- 21 prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
- 22 2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or
- 23 beneficial for medical practices to get paid by VCCs.
- 24 3. Our AMA will engage in legislative and regulatory advocacy efforts to address the
- 25 growing and excessive electronic funds transfer (EFT) add-on service fees charged by
- 26 payers when paying physicians, including advocacy efforts directed at:
 - 27 a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory
 - 28 guidance affirming physicians’ right to choose and receive timely basic EFT
 - 29 payments without paying for additional services.
 - 30 b. CMS enforcement activities related to this issue.
 - 31 c. Physician access to a timely no fee EFT option as an alternative to VCCs.
- 32

33 AMA policy provides a clear and longstanding framework for addressing virtual VCC payments
34 EFT fees, and enforcement of Administrative Simplification requirements. In 2015, the House of
35 Delegates adopted Policy H-190.955, which commits the AMA to educating physicians about the
36 costs and mechanics of VCC payments, promoting advance disclosure of transaction fees and payer
37 incentives, and protecting physician choice through an initial opt-in model, meaningful opt-out
38 rights and opposition to contractual provisions that require acceptance of VCCs as a condition of
39 network participation.

40
41 In 2022, the AMA adopted Policy D-190.970, directing the AMA to advocate that CMS investigate
42 and resolve violations of HIPAA Administrative Simplification requirements, ensure transparency
43 in enforcement processes, and oppose improper payment practices, including illegal EFT fees and
44 failure to provide compliant payment options.

45
46 In 2023, the AMA adopted Policy D-190.968, which strengthens this framework by promoting
47 physician access to a timely, no-fee EFT option, opposing excessive EFT add-on service fees,
48 urging CMS to clarify physicians’ right to receive basic EFT payments without additional charges,
49 and supporting robust enforcement of existing regulatory standards.

1 Together, these policies, adopted in 2015, 2022, and 2023, establish a comprehensive advocacy
2 foundation centered on transparency, physician autonomy, regulatory enforcement, and protection
3 against improper transaction fees. They provide the basis for the AMA’s ongoing regulatory and
4 legislative efforts to ensure physicians can receive timely electronic payments without coercive
5 practices or unnecessary financial loss.

6
7 DISCUSSION

8
9 The Board of Trustees understands the concerns that prompted Resolution 819 and recognizes the
10 challenges that VCCs and electronic processing fees pose for physician practices. AMA advocacy
11 is squarely focused on addressing these issues from both the regulatory and legislative
12 perspectives.

13
14 For example, in [June 2025](#) and [July 2025](#) letters to Department of Health and Human Services
15 (HHS) and CMS, the AMA emphasized how VCCs and fee-based EFT payments continue to pose
16 significant problems for physicians, as these payment methods impose fees (up to five percent of
17 the claim amount) that can add up to substantial financial losses to practices that are already
18 struggling. Physician practices that lose up to five percent of claims payments due to EFT fees are
19 less able to invest in the additional staff, medical equipment, data analytics, and information
20 technology that could improve care access and quality. This is an especially salient issue for rural
21 physician practices operating on thin margins, which are already struggling to provide timely care
22 without having to factor in the greater administrative burdens and fees that come with receiving
23 electronic payments. The AMA has continued to raise these concerns in subsequent federal
24 discussions and stakeholder engagement.

25
26 In addition, these fees represent a reduction in the negotiated rate the health plan has agreed to pay
27 the physician for a rendered service. Moreover, VCC and EFT fee programs are often opaque, with
28 many physicians unaware of the associated financial losses until months after being unwittingly
29 charged these fees. To compound these issues, the process of reversing and reissuing payments via
30 a preferred method is often so tedious and time-consuming that physicians simply cannot afford to
31 spend the time to request corrections. The lack of transparency, in part, results from coercive
32 business practices, with most plans and vendors defaulting to fee-based transactions and forcing
33 physician practices to “opt out” of VCCs or fee-based EFT. We have heard from many practices
34 that this “opt out” process can be extremely time-consuming and administratively burdensome.
35 Taken together, these negative factors have led to suboptimal EFT utilization: the most recently
36 available data from the 2024 CAQH Index shows EFT adoption at only 77 percent, compared with
37 98 percent for electronic claims.

38
39 To address these concerns with HHS and CMS and ensure that EFT standard transactions reap their
40 intended benefits, the AMA has recommended that the agencies vigorously enforce existing
41 guidance regarding health plans’ use of VCC or EFT fee-based programs.

42
43 The AMA has also urged the agencies to issue additional guidance that will protect physicians from
44 unfair business practices by:

- 45
- 46 • Clarifying that health plans and their contracted vendors cannot require a physician to
47 agree to additional services and/or fees as a condition of receiving payments using the EFT
48 standard;
 - 49 • Requiring health plans and their vendors to prominently offer an ACH EFT option with no
50 associated fees;

- 1 • Requiring health plans and their vendors to offer VCC or fee-based EFT strictly using an
2 opt-in model, under which physicians receive clear and full information about the
3 additional costs involved and proactively agree to using this method before any payments
4 are issued; and
- 5 • Requiring all health plans and their vendors to contact physicians in advance of any
6 expiration of EFT enrollment and facilitate swift reenrollment vs. automatically defaulting
7 to VCC or fee-based EFT payments.

8
9 Ultimately, AMA wants the agencies to support the EFT regulation’s underlying goals and create
10 the much-needed transparency that physicians and other providers need to make informed,
11 independent choices about the appropriate payment method for their practices.

12 *Legislative Action*

13
14
15 In addition, the AMA is proceeding with advocacy before Congress to act on behalf of physicians.
16 The AMA helped introduce the “No Fees for EFTs Act” ([H.R. 6487](#)) introduced by Representative
17 Greg Murphy, MD (R-NC) in November 2023 and companion legislation in the Senate ([S. 3805](#)),
18 led by Senators Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA). These bills, which
19 received [bipartisan support](#), would prohibit health plans from “imposing fees on providers for EFTs
20 and health care payment and remittance advice transactions.” During that Congress, AMA staff
21 worked with Congressional champions to address proposed legislative language changes and to
22 preserve provisions aligned with AMA policy objectives. Although negotiations ultimately stalled
23 and the legislation was not advanced before the close of the 118th Congress, the issue remains a
24 priority. The AMA continues to work with Congressional champions to reintroduce the “No Fees
25 for EFTs Act” this Congress. Progress was slowed by staff transitions within key Congressional
26 offices; however, AMA staff have met with the bill sponsors and their teams and understand that
27 the legislation remains a priority. The AMA anticipates continued engagement aimed at securing
28 reintroduction in the near term.

29
30 State legislatures are also increasingly examining the use of VCCs by health plans and their
31 contracted vendors. The AMA has supported state-level efforts consistent with existing AMA
32 policy and has worked with state medical societies and coalition partners to advance legislation that
33 promotes transparency, voluntary physician choice, and access to no-fee EFT options. Several
34 states, including Alabama, Arizona, Georgia, and New York, have enacted legislation designed to
35 increase transparency in electronic payment practices, clarify physician choice, and limit the
36 imposition of excessive transaction fees. These laws generally require clearer disclosure of
37 payment methods and associated fees, prohibit default enrollment into VCC programs without
38 affirmative consent, and, in some cases, restrict the ability of plans or vendors to condition
39 participation on acceptance of fee-based payment mechanisms. Going forward, the AMA will
40 continue to collaborate with interested state medical associations, monitor emerging legislative
41 proposals, and support state initiatives that address coercive payment practices, enhance disclosure
42 requirements, and reinforce physicians’ right to timely, no-fee electronic payment options.

43
44 State efforts reflect growing recognition that VCC practices can erode negotiated payment rates
45 and impose avoidable administrative burden on physician practices. While statutory approaches
46 vary by state, the common themes include strengthening opt-in protections, enhancing transparency
47 around fees and incentives, and reinforcing the availability of lower-cost ACH EFT options. The
48 AMA continues to monitor these developments and support state medical associations as they
49 pursue reforms consistent with AMA policy.

1 ACTION ITEMS

2
3 The Board of Trustees recommends that, consistent with Resolution 819 and existing AMA policy,
4 the AMA pursue the following implementation priorities over the coming year:

- 5
6 1. The AMA will engagement with HHS and CMS to press for stronger enforcement of
7 existing HIPAA Administrative Simplification requirements related to electronic payment
8 standards.
9 2. The AMA will request that CMS issue clarifying guidance affirming physicians' right to
10 receive timely ACH EFT payments without being required to purchase additional services
11 or incur add-on processing fees and reinforcing that nonstandard payment options must not
12 undermine the intent of the EFT standard.
13 3. The AMA will work with congressional champions to reintroduce and advance the "No
14 Fees for EFTs Act" in the 119th Congress
15 4. The AMA will support state medical societies in state legislative and regulatory efforts that
16 increase transparency around VCC use, limit coercive opt-out structures, or restrict
17 excessive electronic payment fees, consistent with existing AMA policy.
18 5. The AMA will communicate with physicians regarding the financial implications of VCC
19 and fee-based EFT programs and reinforce available information about compliant ACH
20 EFT options and physician rights under existing standards.
21

22 CONCLUSION

23
24 The financial and administrative burdens associated with VCC payments and fee-based EFT
25 programs remain significant and persistent. Despite longstanding statutory standards under HIPAA
26 Administrative Simplification and the Affordable Care Act's EFT requirements, many health plans
27 and their vendors continue to default physicians into payment methods that impose avoidable fees,
28 reduce negotiated reimbursement, and create unnecessary administrative burden. The Change
29 Healthcare cyberattack further exposed vulnerabilities in electronic payment systems and
30 highlighted the consequences of inadequate enforcement and oversight.
31

32 Through regulatory advocacy, legislative engagement, and state-level collaboration, the AMA has
33 continued to advance policies designed to protect physician autonomy, support transparency, and
34 secure access to timely, no-fee electronic payments. However, relief will require stronger
35 enforcement by CMS, clear regulatory guidance, and Congressional action to eliminate improper
36 transaction fees. The Board of Trustees will continue to pursue a coordinated legislative and
37 regulatory strategy consistent with Policies H-190.955, D-190.968, and D-190.970. The
38 recommendations below also include rescission of Policy D-190.965, as its reporting directive has
39 been fulfilled through submission of this report.
40

41 RECOMMENDATIONS

42
43 The Board of Trustees recommends the following be adopted and the remainder of the report be
44 filed.
45

- 46 1. That Policy D-190.965 be amended to read as follows:

47
48 Our American Medical Association report at the Annual 2026⁷ Meeting on the progress of,
49 and action items for implementation of AMA Policies D-190.970, H-190.955, and D-
50 190.968. (Update HOD Policy)

- 1
 - 2
 - 3
2. That our AMA reaffirm Policies H-190.955, “Virtual Credit Card Payments;” D-190.968, “Amend Virtual Credit Card and Electronic Funds Transfer Fee;” and D-190.970, “CMS Administrative Requirements.” (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REPORT 28 OF THE BOARD OF TRUSTEES (A-26)
Accountability in the Use of Augmented Intelligence for Prior Authorization
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted amended Resolution 823, which strengthened Policy D-480.956, “Use of Augmented Intelligence for Prior Authorization,” and directed the Board of Trustees to report back to the 2026 Annual Meeting on actions taken. This report responds to that directive while also recognizing that more recent legislative and regulatory developments may not be fully reflected due to report preparation timelines.

The rapid expansion of insurer use of augmented intelligence (AI) in prior authorization (PA) and claims review presents significant risks to patient access, clinical autonomy, and administrative burden. When deployed without comprehensive oversight, transparency, and clinician involvement, AI-enabled tools can accelerate denials, undermine individualized patient assessment, and scale opaque decision-making processes that are difficult for patients and physicians to challenge. Testimony in support of Resolution 823 emphasized that clear guardrails are necessary for AI to enhance administrative efficiency without replacing independent clinical judgment or creating new barriers to medically necessary care.

Consistent with Policy D-480.956 and related policy H-480.931, the AMA has advanced a comprehensive advocacy strategy at the federal and state levels. The AMA has supported federal legislation, including the “Improving Seniors’ Timely Access to Care Act of 2025” (H.R. 3514/S. 1816), which would require Medicare Advantage plans to publicly report their use of AI and related technologies in PA decisions. The AMA has also engaged Congress, the Office of Science and Technology Policy, and the Centers for Medicare & Medicaid Services to promote requirements that insurer AI use be grounded in evidence-based clinical guidelines; that adverse determinations informed by AI be reviewed by qualified, specialty-appropriate clinicians who are not incentivized to deny coverage for care; and that patients and physicians have access to the criteria and information underlying coverage decisions.

At the state level, the AMA has supported enactment of guardrails limiting insurer reliance of AI in utilization management, including requirements for individualized clinical review, audit authority, public reporting, and prohibitions on automated systems serving as the sole basis for medical necessity denials. In parallel, the AMA has worked within national AI technical standards processes to improve transparency regarding whether human review occurred and to facilitate identification of reviewer specialty.

The AMA has also emphasized safeguards to protect continuity of care, including requiring direct clinician review of patient records before any AI-flagged denial of previously approved medications, strengthening appeals processes, and advancing protections against algorithmic discrimination to ensure equitable access to care.

While progress has been made, insurer use of AI in coverage determinations continues to expand, often without sufficient visibility or enforceable safeguards. The AMA will continue to advocate for legislative and regulatory reforms that ensure AI-supported PA processes remain transparent, clinically grounded, equitable, and accountable to qualified physicians. This ongoing work advances the goals of Policy D-480.956 and reinforces the AMA’s leadership in protecting patients and physicians as AI becomes more deeply embedded in health care coverage decisions.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 28-A-26

Subject: Accountability in the Use of Augmented Intelligence for Prior Authorization
(Res. 823-I-25)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

1 At the 2025 Interim Meeting, the House of Delegates (HOD) adopted Resolution 823, “Accountability in
2 the Use of Augmented Intelligence for Prior Authorization,” which modified existing AMA Policy D-
3 480.956, “Use of Augmented Intelligence for Prior Authorization” to read as follows:
4

- 5 1. Our American Medical Association will work with stakeholders to advocate for legislative and/or
6 regulatory action for greater regulatory oversight related to the use of augmented intelligence for
7 review of patient claims and prior authorization requests, including whether insurers and/or
8 contracted third parties are using a thorough and fair process that:
 - 9 a. is based on accurate and up-to-date clinical criteria derived from national medical
10 specialty societies’ evidence-based guidelines and peer-reviewed clinical literature.
 - 11 b. includes reviews by physicians and other health care professionals who are not
12 incentivized to deny care and with expertise for the service under review.
 - 13 c. provides for transparency and accountability over the use of augmented intelligence for
14 all medical service denials, to include a direct review of patient records by a qualified
15 clinician.
 - 16 d. requires direct review of the patient record by a qualified clinician of all medications
17 flagged for denial by augmented intelligence platforms that were previously approved by
18 payers.
 - 19 e. provides robust appeals processes and guardrails to prevent algorithmic discrimination
20 and ensure equitable access to care.
- 21 2. Our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of
22 Delegates.
23

24 Resolution 823 amended Policy D-480.956 to more clearly articulate that insurer use of augmented
25 intelligence in claims review and PA must be subject to meaningful regulatory oversight and grounded in
26 a thorough and fair process. As amended, the policy specifies that such processes must be based on
27 accurate and up-to-date clinical criteria derived from national medical specialty societies’ evidence-based
28 guidelines and peer-reviewed literature; include review by physicians and other health care professionals
29 who are not incentivized to deny care and who have expertise in the service under review; provide
30 transparency and accountability for all medical service denials; require direct review of patient records by
31 a qualified clinician, including for medications previously approved by payers; and include robust appeals
32 processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.
33

34 The AMA is actively pursuing legislative and regulatory strategies to advance these guardrails at both the
35 federal and state levels. This report outlines the actions taken before and after adoption of Resolution 823-
36 I-25 to implement the amended policy and fulfill the reporting requirement.

1 AMA POLICY

2
3 Policy D-480.956, “Use of Augmented Intelligence for Prior Authorization” (See above)

4
5 Policy H-480.931, “Assessing the Intersection Between AI and Health Care”

6
7 (9) Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- 8 a. Use of automated decision-making systems that determine coverage limits, make claim
9 determinations, and engage in benefit design should be publicly reported, based on easily
10 accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and
11 disclosed to both patients and their physician in a way that is easy to understand.
- 12 b. Payors should only use automated decision-making systems to improve or enhance efficiencies in
13 coverage and payment automation, facilitate administrative simplification, and reduce workflow
14 burdens. Automated decision-making systems should never create or exacerbate overall or
15 disparate access barriers to needed benefits by increasing denials, coverage limitations, or
16 limiting benefit offerings. Use of automated decision-making systems should not replace the
17 individualized assessment of a patient’s specific medical and social circumstances and payors’
18 use of such systems should allow for flexibility to override automated decisions. Payors should
19 always make determinations based on particular patient care needs and not base decisions on
20 algorithms developed on “similar” or “like” patients.
- 21 c. Payors using automated decision-making systems should disclose information about any
22 algorithm training and reference data, including where data were sourced and attributes about
23 individuals contained within the training data set (e.g., age, race, gender). Payors should provide
24 clear evidence that their systems do not discriminate, increase inequities, and that protections are
25 in place to mitigate bias.
- 26 d. Payors using automated decision-making systems should identify and cite peer-reviewed studies
27 assessing the system’s accuracy measured against the outcomes of patients and the validity of the
28 system’s predictions.
- 29 e. Any automated decision-making system recommendation that indicates limitations or denials of
30 care, at both the initial review and appeal levels, should be automatically referred for review to a
31 physician: (a) possessing a current and valid non-restricted license to practice medicine in the
32 state in which the proposed services would be provided if authorized, and (b) be of the same
33 specialty as the physician who typically manages the medical condition or disease or provides the
34 health care service involved in the request prior to issuance of any final determination. Prior to
35 issuing an adverse determination, the treating physician must have the opportunity to discuss the
36 medical necessity of the care directly with the physician who will be responsible for determining
37 if the care is authorized.
- 38 f. Individuals impacted by a payor’s automated decision-making system, including patients and
39 their physicians, must have access to all relevant information (including the coverage criteria,
40 results that led to the coverage determination, and clinical guidelines used).
- 41 g. Payors using automated decision-making systems should be required to engage in regular system
42 audits to ensure use of the system is not increasing overall or disparate claims denials or coverage
43 limitations, or otherwise decreasing access to care. Payors using automated decision-making
44 systems should make statistics regarding systems’ approval, denial, and appeal rates available on
45 their website (or another publicly available website) in a readily accessible format with patient
46 population demographics to report and contextualize equity implications of automated decisions.
47 Insurance regulators should consider requiring reporting of payor use of automated decision-
48 making systems so that they can be monitored for negative and disparate impacts on access to
49 care. Payor use of automated decision-making systems must conform to all relevant state and
50 federal laws.

1 DISCUSSION

2
3 The AMA’s strategy to address the growing use of AI by payers in claims review and PA includes strong
4 advocacy efforts to pursue legislative and regulatory solutions that ensure meaningful oversight of these
5 tools and the processes surrounding them. Specifically, we support standards requiring that AI-informed
6 determinations be grounded in current, evidence-based clinical guidelines; incorporate independent
7 review by qualified clinicians with relevant expertise; and provide clear transparency, accountability, and
8 robust appeals protections. Together, these reforms are intended to safeguard patient access to medically
9 necessary care and prevent inappropriate, biased, or financially driven denials. The following section
10 includes the steps taken between now and the previous meeting directed at this issue:

11
12 *Insurer use of AI should be based on accurate and up-to-date clinical criteria derived from national*
13 *medical specialty societies’ evidence-based guidelines and peer-reviewed clinical literature.*

14
15 The AMA is establishing and advancing a clear set of federal guardrails for insurer use of AI in coverage
16 decisions. AI-driven automation is increasingly being used to accelerate denials and coverage limitations,
17 with significant downstream burdens for physicians and clinically harmful delays for patients. AMA
18 policy and congressional facing advocacy emphasize that, absent stronger guardrails, AI-enabled
19 processes can undermine individualized patient assessment and contribute to inappropriate denials that
20 patients and physicians struggle to understand and overturn.

21 Consistent with the resolution’s core requirement, AMA policy states that insurer AI used to determine
22 coverage limits, make claim determinations, or engage in benefit design must be based on easily
23 accessible, evidence-based clinical guidelines (not proprietary payer criteria) and disclosed to patients and
24 physicians in an understandable way. The AMA is reinforcing this position in congressional advocacy,
25 urging policymakers to require public reporting and disclosure of AI use and to ensure that the basis for
26 coverage decisions is transparent and clinically grounded rather than opaque or proprietary. In addition,
27 the AMA supports state-based advocacy efforts to advance these guardrails and collaborates with state
28 medical associations and patient advocacy organizations to promote transparency, clinician oversight, and
29 equitable access to care. The AMA has engaged with national organizations, including the National
30 Association of Insurance Commissioners (NAIC), on broader PA and UM reforms that intersect with
31 oversight of automated decision-making tools.

32
33 The AMA is advocating that insurer AI coverage criteria must be accountable to the medical evidence
34 base, requiring payers to identify and cite peer-reviewed studies evaluating system accuracy and the
35 validity of predictions, and to provide affected patients and physicians access to the relevant coverage
36 criteria, results, and clinical guidelines used in the determination. Despite these established guardrails and
37 repeated engagement with policymakers, including communication to the [Senate Committee on Health,](#)
38 [Education, Labor and Pensions](#) and the [Office of Science and Technology Policy](#), AMA’s advocacy
39 underscores that insurer noncompliance and continued opaque AI-driven denials necessitate stronger
40 oversight expectations to ensure AI is used only in ways that reduce administrative burden without
41 restricting medically necessary care.

42
43 *Insurer AI use must include reviews by physicians and other health care professionals who are not*
44 *incentivized to deny care and with expertise for the service under review.*

45
46 The AMA advocates that insurer use of AI in coverage determinations must not substitute for independent
47 clinical judgment, particularly given the real-world pattern of AI enabled automation being used to
48 accelerate denials and compound administrative burden and delays in care. The AMA has therefore
49 advanced guardrails that center on two complementary requirements: (1) case level clinician review that
50 is clinically meaningful and specialty appropriate before an adverse determination is finalized; and (2)

1 structural protections to reduce conflicts of interest and ensure decisions reflect independent medical
2 judgment rather than denial-driven incentives.

3
4 At the case level, AMA policy states that when AI is used for payer coverage limits, claim
5 determinations, or benefit design, payers should be required to ensure that decisions are reviewed by
6 physicians and other health care professionals who are not incentivized to deny care and who have
7 expertise for the service under review, a standard that directly aligns with this resolution’s requirement for
8 specialty appropriate clinician oversight. With the AMA’s support, California enacted Senate Bill 1120
9 (2024 Cal. Stat. ch. 879 (S.B. 1120)) in 2024 which mandates that AI tools used for utilization review or
10 UM decisions comply with a variety of requirements, including that the tool: does not supplant
11 individualized health care provider decision-making; does not directly or indirectly discriminate; be fairly
12 and equitably applied; and be open to audit for compliance. California’s new law also specifies that an AI
13 tool cannot deny, delay, or modify health care services based on medical necessity and that such decisions
14 shall only be made by a physician or health care professional competent to evaluate the specific clinical
15 issues involved. At the federal level, Centers for Medicare and Medicaid Services (CMS) is testing
16 technology-enabled review processes through the Wasteful and Inappropriate Service Reduction (WISeR)
17 model, developed by the Center for Medicare & Medicaid Innovation. The model incorporates the use of
18 advanced analytics, including AI-supported tools, to assist in reviewing certain services within Medicare
19 fee-for-service. CMS has indicated that the model will include safeguards such as clinician review of
20 determinations and documentation regarding the role of AI tools in coverage decisions. The AMA is
21 closely monitoring implementation of the model and engaging CMS to promote transparency,
22 accountability, meaningful physician oversight, robust guardrails, streamlined administrative processes,
23 patient access to timely care, and greater use of evidence-based clinical guidelines consistent with AMA
24 policy governing the use of AI in coverage determinations.

25
26 The AMA is reinforcing the need for meaningful clinician review in congressional advocacy by pressing
27 for requirements that adverse AI recommendations be subject to physician review before finalization and
28 that coverage decisions be grounded in independent clinical judgment rather than opaque automated
29 workflows. To facilitate and track human review of payer AI use, the AMA was successful in modifying
30 national AI technical standards that indicate whether a human was involved in the coverage decisions and
31 an optional code to allow for sending the reviewer’s specialty information.

32
33 At the structural level, the AMA is emphasizing that insurer review processes and UM governance must
34 be designed to prevent conflicts of interest from shaping clinical outcomes. In its 2026 Medicare
35 Advantage comment [letter](#), the AMA urged strengthening UM committee composition and independence,
36 recommending that these committees include practicing physicians, and that independent physician
37 participation be increased to a majority to ensure that coverage criteria and adverse determinations are
38 informed by practicing clinician expertise and insulated from incentives that could compromise
39 independent clinical judgment.

40
41 Despite these established guardrails, AMA’s ongoing advocacy reflects that insurer AI use continues to
42 undermine independent clinical review in practice, reinforcing the need for stronger oversight
43 expectations to ensure that AI-supported coverage decisions remain accountable to qualified, specialty-
44 appropriate clinicians and do not become a vehicle for inappropriate denials and avoidable care delays.

45
46 *Insurers provide transparency and accountability over the use of AI for all medical service denials, to*
47 *include a direct review of patient records by a qualified clinician.*

48
49 The AMA advocates that insurer use of AI-driven automated decision-making in coverage determinations
50 must be subject to clear transparency and real accountability. Opaque AI-enabled denials can scale
51 quickly, exacerbate PA burdens, and create avoidable delays in medically necessary care. AMA’s policy

1 and congressional-facing advocacy underscore that patients and physicians must be informed and
 2 empowered to question AI-supported coverage decisions, and that stronger oversight expectations are
 3 warranted when insurers use these systems for coverage, claims determinations, and benefit design.
 4

5 At the point of denial, the AMA is advancing clear transparency expectations. AMA policy calls for
 6 insurer use of automated decision-making systems to be publicly reported and disclosed to patients and
 7 physicians in an easy-to-understand manner, including clear communication that AI was used when it was
 8 part of the denial decision-making. The AMA further specifies that individuals impacted by an insurer’s
 9 automated decision-making system, including patients and their physicians, must have access to all
 10 relevant information underpinning the coverage determination, including the coverage criteria, the results
 11 that led to the determination, and the clinical guidelines used. In parallel, the AMA warns that a core
 12 failure mode of insurer automation is the absence of individualized review, where denials are made
 13 without patient specific assessment and, in some cases, without opening or reviewing the patient’s
 14 medical record, underscoring why transparency must be paired with meaningful clinical accountability
 15 whenever AI is used to recommend or trigger a denial.
 16

17 On accountability, the AMA is urging routine auditing and public reporting to detect and correct harmful
 18 patterns. AMA policy calls for insurers using automated decision-making systems to conduct regular
 19 system audits to ensure AI use is not increasing overall or disparate denials/coverage limits or otherwise
 20 reducing access to care, and to make approval, denial, and appeal rate statistics publicly available in a
 21 readily accessible format with patient population demographics to contextualize equity implications.
 22 Notably, the AMA has vigorously advocated for passage of H.R. 3514/S. 1816, the “Improving Seniors’
 23 Timely Access to Care Act of 2025,” which would make important reforms in Medicare Advantage PA
 24 programs. The bill would require Medicare Advantage plans to publicly disclose the percentage and
 25 number of PA requests that were denied in the previous plan year “through the utilization of decision
 26 support technology, artificial intelligence technology, machine-learning technology, clinical decision-
 27 making technology, or any other technology specified by the Secretary,” as well as disclose and describe
 28 the technology utilized in evaluating PA requests. In December 2025, the AMA led over 120 physician
 29 organizations in a sign-on [letter](#) to congressional leadership expressing long-standing support for this bill
 30 and the improved transparency it would bring to Medicare Advantage PA programs, including this critical
 31 public reporting of plans’ use of AI in coverage determinations.
 32

33 AMA efforts have supported several states that have now enacted laws that establish guardrails that
 34 directly constrain insurer use of AI and automated tools in UM and adverse determinations. In Maryland
 35 (H.B. 820), plans must report quarterly to the Insurance Commissioner whether an “artificial intelligence,
 36 algorithm, or other software tool” was used in an adverse decision, and they must ensure that any such
 37 tool is applied to the patient’s individual medical history and clinical circumstances, does not replace
 38 provider judgment, avoids discrimination, is regularly evaluated for accuracy and reliability, and does not
 39 use patient data beyond its stated purpose. In Arizona (H.B. 2175), a claim denial based on medical
 40 necessity requires individual review by the plan’s medical director, exercising independent medical
 41 judgment and not relying solely on recommendations from other sources. Nebraska (LB 77) bars an AI
 42 algorithm from being the sole basis for denying, delaying, or modifying services based on medical
 43 necessity, and requires disclosure when AI is used in UM. Texas (S.B. 815) prohibits the use of
 44 automated decision systems to make adverse determinations, while allowing such tools for administrative
 45 support or fraud detection, and clarifies the Insurance Commissioner’s authority to audit and inspect these
 46 tools.
 47

48 The NAIC Big Data and Artificial Intelligence Working Group has made insurer use of AI a sustained
 49 regulatory priority and is encouraging state insurance regulators to apply consistent governance
 50 expectations. In December 2023, NAIC issued a model bulletin for states to adopt, reminding insurers that
 51 AI-enabled decisions affecting consumers remain subject to existing state laws (including unfair trade

1 practice and other consumer protection requirements), and outlining baseline governance expectations and
 2 the types of information regulators may request during examinations or investigations. To date, 25 states
 3 have adopted the bulletin. NAIC has also released data describing how health plans report using AI across
 4 functions such as contracting, fraud detection, pricing, plan design, risk adjustment, risk management,
 5 marketing, data processing, and claims determinations—information that can inform ongoing evaluation
 6 of state proposals addressing payer use of clinical algorithms and AI in medical necessity decision-
 7 making. AMA contributed suggestions for the NAIC survey of health insurers inquiring how they are
 8 using AI, including in PA and other UM. AMA provided significant input on the recently released NAIC
 9 PA white paper. AMA shared perspectives on and has been monitoring implementation of the NAIC
 10 model AI bulletin that covers all insurance.

11
 12 At its 2025 Summer Meeting, the National Council of Insurance Legislators (NCOIL) Financial Services
 13 & Multi-Lines Issues Committee considered draft legislation on insurers’ use of AI and specifically in the
 14 claims process. The Committee heard from stakeholders including the AMA, who supported guardrails
 15 around health plans’ use of AI in the claims determination process, while representatives from the
 16 insurance industry discouraged the committee from developing any model, calling it premature. It seems
 17 likely that the committee will continue to discuss potential model legislation at upcoming meetings.

18
 19 The AMA’s broader advocacy also emphasizes that current protections remain insufficient and that AI-
 20 driven denials continue to occur without adequate visibility and individualized review, reinforcing the
 21 need for stronger oversight expectations to ensure AI improves administrative efficiency without
 22 becoming a mechanism for inappropriate denials and delayed care.

23
 24 *Insurers require direct review of the patient record by a qualified clinician of all medications flagged for*
 25 *denial by AI platforms that were previously approved by payers.*

26
 27 The AMA is advancing clear guardrails across its policy and federal advocacy to ensure that insurer use
 28 of AI does not create new pathways to interrupt medically necessary medications that have already been
 29 approved and initiated. In the AMA’s view, AI may be used to flag cases for review, but it must never be
 30 used to automatically deny, terminate, or disrupt a previously approved medication, particularly in
 31 continuation or renewal scenarios where patients are clinically stable and interruptions can cause harm
 32 and compound administrative burden. The AMA has consistently emphasized that PA related disruptions
 33 already undermine continuity of care, and that deploying AI in these workflows without strong safeguards
 34 risks scaling inappropriate denials and worsening care delays.

35
 36 AMA policy requires that any automated recommendation indicating a denial or limitation of care be
 37 automatically referred for physician review prior to any final determination, with the reviewer possessing
 38 appropriate licensure and specialty alignment, and with a meaningful opportunity for clinical discussion
 39 before an adverse decision is issued. This “AI flags, clinicians decide” construct is the factual backbone
 40 for requiring direct review of the patient record by a qualified clinician before any AI-triggered
 41 medication denial is finalized. The AMA is advancing the same principle in congressional-facing
 42 advocacy, warning that automated decision-making must not replace individualized assessment of patient
 43 specific needs, must allow flexibility to override automated outputs, and must not be based on generalized
 44 “similar patient” logic.

45
 46 The AMA is taking these guardrails directly to federal policymakers. In engagement with Congress, the
 47 AMA is urging stronger transparency and oversight when payers use automated decision-making for
 48 coverage and benefit determinations, emphasizing that patients and physicians must be empowered to
 49 question automated decisions and that these systems must not override clinical judgment. In related
 50 congressional advocacy, the AMA is highlighting patterns showing inadequate individualized review and

1 is calling for guardrails that include physician oversight for adverse AI-driven determinations and a
2 pathway to ensure the treating physician can meaningfully engage before a denial is finalized.

3
4 In parallel, the AMA is pressing CMS to ensure coverage criteria and medical necessity determinations,
5 particularly for prescription drugs, are grounded in sound clinical validity and transparency, noting the
6 importance of protections for beneficiaries who rely on medications to maintain health and wellbeing.
7 The AMA is supporting prohibitions on reopening favorable medical necessity decisions absent good
8 cause, reinforcing the core reliance interest that patients and physicians should be able to depend on prior
9 approvals without fear of subsequent reversal, an essential principle when AI is introduced into
10 renewal/continuation workflows.

11
12 *Insurers must provide robust appeals processes and guardrails to prevent algorithmic discrimination and*
13 *ensure equitable access to care.*

14
15 The AMA has consistently advocated that insurer use of AI in UM must be paired with practical, patient-
16 centered safeguards. When automated systems accelerate denials or restrict coverage without meaningful
17 checks, patients experience harmful delays and physicians face escalating administrative burden. The
18 AMA is emphasizing that robust, workable appeals processes are not optional; they are a necessary
19 backstop to ensure that inappropriate or erroneous AI-influenced denials can be promptly corrected and
20 that patients are not deprived of medically necessary care.

21 Consistent with this resolution, AMA policy calls for insurer automated decision-making that
22 recommends a denial or limitation to be referred for physician review before a final determination, and
23 for that same clinician-centered safeguard to apply across the review continuum, including at the appeals
24 level. The AMA’s advocacy highlights that appeals processes frequently function poorly in practice, even
25 when denials are inappropriate: available evidence shows that only a small fraction of Medicare
26 Advantage PA denials are appealed (11.5 percent in 2024), yet a substantial share of appealed denials are
27 overturned (80.7 percent in 2024), underscoring that many patients may forgo medically necessary care
28 because the appeals pathway is too burdensome, too slow, or too opaque to navigate. This pattern
29 reinforces why appeals must be designed to work in real world clinical settings: timely, accessible, and
30 capable of meaningful review by qualified clinicians.

31
32 In addition, the AMA is urging that safeguards against algorithmic discrimination be built into insurer AI
33 use so that automated decision-making does not systematically disadvantage certain patients or reduce
34 equitable access to care. AMA policy calls for payers to demonstrate that automated systems do not
35 discriminate and to implement protections to mitigate bias that could affect coverage determinations.

36 37 CONCLUSION

38
39 The AMA has taken substantial and coordinated action across federal and state advocacy channels to
40 advance oversight, transparency, and accountability in the use of AI in PA and coverage determinations.
41 Through comment letters, congressional engagement, technical standards development, support of federal
42 legislation, and state-level policy advancement, the AMA has reinforced the core guardrails articulated in
43 policy D-480.956 and H-480.931.

44
45 Specifically, the AMA has advanced requirements that insurer AI use be grounded in evidence-based
46 clinical guidelines; that adverse determinations informed by AI be subject to review by qualified,
47 specialty-appropriate clinicians who are not incentivized to deny care; that patients and physicians receive
48 clear disclosure when AI is used and have access to the criteria and data underlying determinations; that
49 previously approved medications not be disrupted without individualized clinician review; and that
50 appeals processes and anti-discrimination safeguards function effectively in practice.

1
2 Despite these efforts, insurer use of AI in UM continues to expand in ways that risk accelerating
3 inappropriate denials, increasing administrative burden, and delaying medically necessary care. The
4 AMA’s advocacy therefore remains ongoing and focused on strengthening enforceable guardrails,
5 improving transparency, and ensuring that AI enhances administrative efficiency without supplanting
6 individualized clinical judgment or compromising patient access.

7
8 The Board of Trustees will continue to monitor legislative, regulatory, and market developments related
9 to payer use of AI and will report back to the House of Delegates as appropriate.

10
11 RECOMMENDATIONS

12
13 The Board of Trustees recommends that the following be adopted, and the remainder of the report be
14 filed.

- 15
16 1. Our American Medical Association (AMA) will:
 - 17 1) Advance federal advocacy to ensure that insurer use of AI in prior authorization and
18 claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines
19 derived from national medical specialty societies and peer-reviewed literature.
 - 20 2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that
21 AI-informed adverse determinations be subject to review by qualified, specialty-
22 appropriate clinicians who are not incentivized to deny coverage for care, and to ensure
23 that automated systems do not supplant individualized clinical judgment.
 - 24 3) Support and seek advancement of federal legislation to promote transparency in
25 Medicare Advantage prior authorization programs, including public reporting of AI and
26 automated decision-making use.
 - 27 4) Advocate for enhanced transparency and accountability in insurer use of AI, including
28 clear disclosure when AI is used in coverage determinations and meaningful access for
29 patients and physicians to the criteria, clinical guidelines, and data underlying those
30 determinations.
 - 31 5) Press for safeguards protecting continuity of care, including requirements that
32 previously approved medications not be denied or disrupted based solely on AI-
33 generated recommendations without direct review of the patient record by a qualified
34 clinician.
 - 35 6) Support development and adoption of state-level guardrails that limit reliance on
36 automated systems as the sole basis for medical necessity denials and promote clinician
37 oversight, audit authority, and protections against algorithmic discrimination.
 - 38 7) Engage in national AI technical standards discussions to strengthen transparency
39 regarding whether human review occurred in coverage determinations and to facilitate
40 identification of reviewer specialty. (Directive to Take Action)
- 41
42 2. That item two of Policy D-480.956, “Use of Augmented Intelligence for Prior Authorization,” be
43 rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-26)

Introduced by: Oklahoma, Mississippi

Subject: Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to
Protect Public Health and Youth Safety

Referred to: Reference Committee B

- 1 Whereas, newer kratom products concentrated with 7-hydroxymitragynine (7-OH), a potent
2 opioid-like compound far stronger than traditional kratom leaf, pose heightened risks of
3 addiction, overdose, and other harms, prompting regulatory concerns due to threats to
4 American consumers^{1,2}; and
5
- 6 Whereas, these 7-OH products are often marketed in child-appealing forms such as flavored
7 shapes and brightly colored packaging, contributing to rising pediatric exposures reported to
8 U.S. poison centers and increased access by minors^{3,4}; and
9
- 10 Whereas, national survey data from the Substance Abuse and Mental Health Services
11 Administration indicate that tens of thousands of U.S. adolescents aged 12–17 have used
12 kratom, based on estimated prevalence rates^{3,5}; and
13
- 14 Whereas, published studies report that kratom is used for perceived stimulant and mood-
15 enhancing effects, including for focus, studying, and recreational purposes^{3,5}; and
16
- 17 Whereas, data from U.S. poison control centers demonstrate that approximately 10% of
18 reported kratom exposures involve individuals under 20 years of age, including children under
19 13³; and
20
- 21 Whereas, high-potency and concentrated kratom products, including those containing 7-
22 hydroxymitragynine (7-OH), may deliver unpredictable and excessive doses, increasing the risk
23 of toxicity^{3,5}; and
24
- 25 Whereas, reported outcomes from kratom exposures include moderate to severe adverse
26 effects requiring medical evaluation and hospitalization, with documented risks of dependence
27 and substance use disorder^{3,5}; and
28
- 29 Whereas, cases of neonatal abstinence syndrome mimicking opioid withdrawal have been
30 documented in infants born to mothers using kratom chronically during pregnancy, underscoring
31 risks to the youngest and most vulnerable children⁶; and
32
- 33 Whereas, public health officials and physicians warn that high-potency kratom products are
34 expanding rapidly in commercial markets and disproportionately appealing to youth, while no
35 adequate and well-controlled clinical trials demonstrate kratom’s safety or efficacy for any
36 medical use, leading medical organizations to advise clinicians to counsel patients against
37 use^{2,7}; and

1 Whereas, the American Medical Association (AMA) recommends that kratom be regulated by
2 the Food and Drug Administration, that its safety and efficacy be established through rigorous
3 clinical trials prior to marketing or over-the-counter sales, and that unregulated kratom products
4 constitute a serious public health concern (AMA Policy H-95.903)⁸; therefore be it
5

6 RESOLVED, that our American Medical Association our AMA amend policy H-95.903 by
7 addition, Regulate Kratom and Ban Over-The-Counter Sales, to read:
8

- 9 1. Our American Medical Association recommends the safety and efficacy of kratom, and its
10 derivatives, should be determined through research and clinical trials and subsequently
11 evaluated by the relevant regulatory entities for its appropriateness for sale and potential
12 oversight via the Controlled Substances Act, before it can be marketed, purchased, or
13 prescribed.
- 14 2. Our AMA recommends individuals who are currently using kratom for pain management
15 or other conditions should have access to appropriate medical care to manage
16 their conditions and withdrawal symptoms, if needed.
- 17 3. Our AMA recommends individuals who are using kratom only for personal use should not
18 face criminal consequences.
- 19 4. Our AMA recommends kratom, and its derivatives, should be regulated by the
20 FDA, and its safety and efficacy should be determined through clinical trials before it can
21 be marketed or prescribed as treatment for any condition;

22 (Modify Current HOD Policy); and be it further
23

24 RESOLVED, that our AMA adopt a policy to ban the sale, distribution, or marketing of 7-
25 hydroxymitragynine (7-OH) concentrated kratom products (New HOD Policy); and be it further
26

27 RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom
28 products as adulterated or misbranded when sold in child-appealing forms, prohibit their
29 availability in physical retail stores and online platforms accessible to minors (Directive to Take
30 Action); and be it further
31

32 RESOLVED, that our AMA advocate for public education campaigns by physicians warning
33 parents and youth of 7-OH kratom risks, and support research into pediatric exposures and
34 optimal regulatory frameworks. (Directive to Take Action)
35

Fiscal Note: Minimal – less than \$5,000

Received: 4/7/26

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2. Eggleston W, Stoppacher R, Suen K, Marraffa JM, Nelson LS. Kratom use and toxicities in the United States. *Pharmacotherapy.* 2019;39(7):775-777. doi:10.1002/phar.2280 [Kratom Use and Toxicities in the United States](#)
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4. Olsen EO, O'Donnell J, Mattson CL, Schier JG, Wilson N. Notes from the field: unintentional drug overdose deaths with kratom detected - 27 states, July 2016-December 2017. *MMWR Morb Mortal Wkly Rep.* 2019;68(14):326-327. doi:10.15585/mmwr.mm6814a2 [Notes from the Field: Unintentional Drug Overdose Deaths with Kratom Detected - 27 States, July 2016-December 2017 | MMWR](#)

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6. Singh D, Müller CP, Vicknasingam BK. Kratom (*Mitragyna speciosa*) dependence, withdrawal symptoms, and craving in regular users. *Drug Alcohol Depend*. 2014;139:132-137. doi:10.1016/j.drugalcdep.2014.03.017 [Kratom \(Mitragyna speciosa\) dependence, withdrawal symptoms and craving in regular users – ScienceDirect](#)
7. American Medical Association House of Delegates. Policy H-95.903: Kratom. American Medical Association; reaffirmed 2023. H-95.903 [Regulate Kratom and Ban Over-The-Counter Sales | AMA](#)

RELEVANT AMA POLICY

Regulate Kratom and Ban Over-The-Counter Sales H-95.903

1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-26)

Introduced by: Florida, Texas, Oklahoma

Subject: Using and Defining “Unsupervised Practice of Medicine”

Referred to: Reference Committee B

1 Whereas, the American Association of Nurse Practitioners (AANP) is advocating for “Full
2 practice authority (FPA)” or “Independent practice” to practice without physician supervision or a
3 collaborative practice agreement; and
4
5 Whereas, FPA is not a legal or regulatory category but a political term used by nursing
6 organizations to describe the removal of physician supervision; and
7
8 Whereas, scope-of-practice laws vary widely, and no state grants complete authority equivalent
9 to physician licensure; and
10
11 Whereas, the AMA believes non-physicians should be supervised under the physician led care
12 team model with direct on-site supervision of non-physician practitioners as the gold standard;
13 and
14
15 Whereas, having a standard terminology would help define our goal of supervised practice in all
16 medical settings; and
17
18 Whereas, nurse practitioners assert that they practice advanced nursing rather than the practice
19 of medicine; yet their day-to-day activities—diagnosing disease, ordering and interpreting
20 diagnostic tests, performing medical procedures, and prescribing medications, including
21 controlled substances—are universally recognized as core components of the practice of
22 medicine as defined in state medical practice acts; and
23
24 Whereas, the practice of medicine is legally distinct from the practice of nursing, with medicine
25 defined as the independent evaluation and treatment of human illness, injury, and disease while
26 nursing is defined as the promotion of health, the prevention of illness, and the management of
27 human responses to health problems within a nursing framework; and
28
29 Whereas, by performing medical diagnostic and therapeutic activities outside the physician-led
30 model, nurse practitioners functionally engage in the practice of medicine while holding a
31 nursing license, creating regulatory inconsistency and patient confusion regarding the level of
32 training associated with these medical acts; therefore be it
33
34 RESOLVED, that our American Medical Association use the term “Unsupervised Practice of
35 Medicine” (UPM) when describing statutory or regulatory efforts that allow nonphysician
36 practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that
37 physician-led, team-based care with appropriate physician supervision remains the gold
38 standard for patient safety and quality care (New HOD Policy); and be it further

1 RESOLVED, that our AMA incorporate the term “Unsupervised Practice of Medicine” in its
2 advocacy materials, public communications, testimony, and educational resources, where
3 appropriate, to clarify the distinction between physician licensure and nonphysician scope
4 expansion (Directive to Take Action); and be it further

5
6 RESOLVED, that our AMA continue to advocate for truth in advertising, transparency in
7 professional identification, and clear communication to patients regarding differences in
8 education, training, and licensure between physicians and nonphysician practitioners.
9 (Directive to Take Action)

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

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-26)

Introduced by: Florida, Texas, Oklahoma

Subject: Support for Independent Evaluation of Outcomes Associated with
Unsupervised Nurse Practitioner Practice

Referred to: Reference Committee B

1 Whereas, the American Medical Association has longstanding policy supporting physician-led,
2 team-based care as the model most consistent with patient safety and quality; and
3

4 Whereas, 27 states currently permit unsupervised practice of medicine (UPM) by nurse
5 practitioners, and some states have allowed UPM for decades; and
6

7 Whereas, many scope-of-practice expansions have occurred without prospective, randomized,
8 or methodologically rigorous comparative studies evaluating patient outcomes when physician
9 supervision is removed; and
10

11 Whereas, existing studies frequently cited in support of expanded scope of practice often
12 examine care delivered within physician-led teams, protocol-based environments, or limited
13 patient populations, rather than independent clinical decision-making; and
14

15 Whereas, objective, high-quality evidence is essential to inform legislators, regulators,
16 physicians, and patients regarding the safety, quality, and appropriate role of unsupervised NP
17 practice; therefore be it
18

19 RESOLVED, that our American Medical Association advocate for and support funding of
20 independent, academically rigorous studies comparing patient outcomes between unsupervised
21 nurse practitioner care and physician-led team-based care, including measures of patient
22 safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-
23 reviewed literature. (Directive to Take Action)

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

Received: 4/9/26

REFERENCES

1. Bernard R. Nonphysician Unsupervised Practice of Medicine: Examining the Evidence. *Mo Med.* 2025 Sep-Oct;122(5):351-356. PMID: 41132456; PMCID: PMC12543343.

RELEVANT AMA POLICY

To Study the Cost and Quality Impact of Non-Physician Provider Employment in the United States of America D-200.973

Our American Medical Association encourages and supports studies to determine the cost and quality impact of non-physician unsupervised practice on all patients.

Our AMA will develop model state legislation that opposes enactment of legislation and supports reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician.

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982

1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.
2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-26)

Introduced by: Florida, New York, Texas, Oklahoma

Subject: D-400.982 Revision

Referred to: Reference Committee B

1 Whereas, Medicare physician fee schedule payment reform is a top priority of the American
2 medical Association and policy D-400.982 was passed in 2024; and
3

4 Whereas, the House of Delegates should received regular updates regarding the AMA's
5 progress on this issue; therefore be it
6

7 **RESOLVED**, that our American Medical Association reaffirm D-400.982:

- 8 1. Our American medical Association will increase media awareness around the 2024 AMA
9 Annual Meeting about the need for Medicare payment reform eliminating budget
10 neutrality reductions, and instituting annual cost of living increases.
- 11 2. Our AMA will step up it's public relations campaign to get more buy-in from the general
12 public about the need for Medicare payment reform.
- 13 3. Our AMA will increase awareness to all physicians about the efforts of our AMA on
14 Medicare payment reform.
- 15 4. Our AMA will advocate for abolition of all MIPS penalties in light of current inadequacies
16 of Medicare payments.

17 (Reaffirm HOD Policy); and be it further
18

19 **RESOLVED**, that our AMA will report back quarterly to the House of Delegates via open forum
20 on these Medicare Payment Reform initiatives. (Directive to Take Action)

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

Received: 4/9/26

REFERENCES

1. D-400.982 in the AMA Policy Compendium

RELEVANT AMA POLICY

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Citation: BOT Rep. 12, A-24; Reaffirmed: Res. 220, I-24;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-26)

Introduced by: Florida, New York, Texas, Oklahoma

Subject: Repeal of the Merit-Based Incentive Payment System (MIPS)

Referred to: Reference Committee B

1 Whereas, the Merit-Based Incentive Payment System (MIPS) has disproportionately harmed
2 rural physician practices¹, clinicians serving minority and socioeconomically disadvantaged
3 populations². CMS data shows that rural clinicians are 30–40% more likely to receive negative
4 or neutral payment adjustments¹. Clinicians treating high-social-risk patients score up to 20
5 points lower on average, resulting in higher penalty rates²; and
6

7 Whereas, private, small, and solo practices face significant structural disadvantages under
8 MIPS, with Health Affairs estimating that such practices spend \$12,800–\$40,000 per clinician
9 annually on MIPS participation and 84% reporting “substantial or extreme” burden—threatening
10 practice viability and accelerating consolidation³; and
11

12 Whereas, MIPS has not demonstrated meaningful improvement in patient outcomes or
13 reductions in healthcare cost, with the Medicare Payment Advisory Commission (MedPAC)
14 concluding in its 2022 Report to Congress that MIPS is “fundamentally flawed,” “not
15 evidence-based,” and “unlikely to improve quality or efficiency,” and with studies showing MIPS
16 scores are not correlated with validated outcome measures⁴; and
17

18 Whereas, physicians spend 200+ hours per year on MIPS-related documentation reducing
19 clinical availability and continuity of care⁵; and
20

21 Whereas, MIPS contributes significantly to physician burnout, with the 2023
22 AMA/Stanford/Press Ganey burnout study identifying federal reporting programs as a top
23 regulatory driver; physicians subjected to high administrative burden are 2.6 times more likely to
24 report intent to leave practice within two years, threatening workforce stability⁶; and
25

26 Whereas, MIPS-related administrative costs and penalties accelerate early physician retirement,
27 particularly among older physicians and those in independent practice, with physicians over age
28 60 being twice as likely to retire early under high regulatory load, while nearly one in five
29 independent physicians report considering closing or selling their practice due to reporting
30 mandates—exacerbating the projected national shortfall of over 100,000 physicians by 2034⁷;
31 and
32

33 Whereas, HOD Policy D-400.982, asks our AMA to advocate for abolition of all MIPS penalties
34 in light of the current inadequacies of Medicare payments; therefore be it
35

36 RESOLVED, that our American Medical Association support full repeal of the Merit-Based
37 Incentive Payment System (MIPS) (New HOD Policy); and be it further
38

39 RESOLVED, that our AMA advocates for immediate administrative relief in MIPS, including
40 expanded low-volume and hardship exemptions for rural and small practices,

1 shortened/streamlined reporting requirements, and reduction of reporting complexity until MIPS
2 is repealed. (Directive to Take Action)

3

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

Received: 4/9/26

RELEVANT AMA POLICY

400.982 AMA Efforts on Medicare Payment Reform D-400.982

Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.

Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.

Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.

Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

BOT Rep. 12, A-24 Reaffirmed: Res. 220, I-24

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

Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 220, I-24

MIPS and MACRA Exemption H-390.838

Our American Medical Association will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices. Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21

Merit-Based Incentive Programs H-478.986

Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.

Res. 213, A-16

Preserving Patient Access to Small Practices Under MACRA D-390.949

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.

3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Res. 243, A-16 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20

Reducing MIPS Reporting Burden D-395.999

Our American Medical Association will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Res. 236, A-18 Reaffirmation: A-19 Reaffirmed: BOT Rep. 13, I-20 Reaffirmed: Res. 220, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-26)

Introduced by: American Association of Clinical Urologists

Subject: Overall Hospital Quality Star Ratings / CMS Star Ratings

Referred to: Reference Committee B

1 Whereas, the Overall Hospital Quality Star Rating (CMS Star Rating) summarizes a variety of
2 measures across 5 areas of quality into a single star rating for each hospital; and
3

4 Whereas, the Overall Star Rating includes 5 measure groups: *Mortality, Safety of Care,*
5 *Readmission, Patient Experience, and Timely & Effective Care;* and
6

7 Whereas, according to our AMA, the most effective way to maximize the complementary skill
8 sets of all health care professionals is to work as part of a physician-led team; and
9

10 Whereas, according to our AMA, physician expertise is widely recognized as integral to quality
11 medical care in the United States. With 7 years or more of postgraduate education and at least
12 10,000 hours of clinical experience through training, physicians are the natural leaders in the
13 overall delivery of health care; and
14

15 Whereas, patients are asked to qualitatively assess hospital quality via patient surveys; and
16

17 Whereas, physicians have the unique position as leaders of the health care team to qualitatively
18 assess how hospitals embrace quality in the delivery of patient care; therefore be it
19

20 RESOLVED, that our American Medical Association advocate to CMS that the Overall Hospital
21 Quality Star Ratings (CMS Star Ratings) include a 6th measured group defined as *Physician*
22 *Experience* which would include those physicians who have membership on the hospital
23 medical staff. (Directive to Take Action)
24

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

Received: 4/13/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-26)

Introduced by: American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Subject: Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program

Referred to: Reference Committee B

1 Whereas, national hospital data show that in 2022, 52.4% of rural hospitals did not offer
2 obstetric care, reflecting a sustained decline in hospital-based obstetric services; and analyses
3 of rural labor-and-delivery service lines report continued closures since 2020 associated with
4 financial losses and workforce constraints;^{1, 2} and

5
6 Whereas, rural hospital financial viability and emergency transfer capacity may be affected by
7 workforce migration, liability exposure, and service line limitations; and

8
9 Whereas, 64% of foreign-trained physicians practice in medically underserved areas or health
10 professions shortage areas³; and

11
12 Whereas, nearly 21 million Americans live in areas where foreign-trained physicians account for
13 at least half of physicians⁴; and

14
15 Whereas, changes in systems granting J-1 Visas for physicians and other federal administrative
16 or regulatory disruptions can reduce or delay the potential physician workforce in rural
17 areas; and

18
19 Whereas, The Conrad 30 Waiver Program (also known as the Conrad State 30 Program) is a
20 federal initiative in the United States designed to address doctor shortages in underserved
21 communities;⁵ and

22
23 Whereas, the Conrad 30 Waiver program is an essential component for rural health care
24 recruitment, yet the limit of 30 waivers per state has remained stagnant since Congress
25 increased the cap to 30 per state per year in 2003; and

26
27 Whereas, there is substantial state-level variation in use of Conrad 30 waivers, with some states
28 filling all 30 slots rapidly while other states do not use their full allotment; therefore be it

29
30 RESOLVED, that our American Medical Association update existing policy D 255.985
31 "Conrad 30- J1 Visa Waivers" to address current challenges and modernize the
32 program by addition as follows:

- 33 • advocate for the redistribution (or recapture) of unused waiver capacity to high-need
34 states; and
- 35 • advocate for the streamlining of administrative requirements to shorten timelines for
36 employers and physicians, such as establishing a medical national interest
37 exception and implementing mandatory expedited processing for physician and medical
38 trainee applicants.

39 (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 4/13/26

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3. Malayala S, Adhikari R, Vasireddy D, Atluri P, Bali A. Medically underserved areas and International Medical Graduates (IMGs) in the United States: challenges during the COVID-19 era. *J Community Hosp Intern Med Perspect*. 2021 Jun 21;11(4):457–463. doi: 10.1080/20009666.2021.1915548. PMID: 34211648; PMCID: PMC8221155. <https://pmc.ncbi.nlm.nih.gov/articles/PMC8221155/>
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5. <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>

RELEVANT AMA POLICY

1. Conrad 30 J-1 Visa Waivers D 255.985 (2024.)
2. Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access H-420.946 (2024.)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-26)

Introduced by: Virginia

Subject: Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness

Referred to: Reference Committee B

1 Whereas, our American Medical Association encourages hospitals to incorporate disaster plans
2 that address barriers to staff responses during disasters, as stated in H-225.941; and
3

4 Whereas, critical medical treatments such as dialysis, chronic oxygen therapy, chemotherapy,
5 and radiation therapy are essential for patient survival and require coordinated planning during
6 emergencies; and
7

8 Whereas, interdisciplinary models of cooperative planning involving city/regional authorities,
9 hospitals, physicians, medical equipment providers, and transportation companies can enhance
10 disaster preparedness and response; therefore be it
11

12 RESOLVED, that our American Medical Association develop model state legislation and
13 guidelines for incorporating critical medical treatment planning into emergency/disaster
14 preparedness plans (Directive to Take Action); and be it further
15

16 RESOLVED, that our AMA support interdisciplinary cooperative planning agreements to ensure
17 continuity of critical medical treatments during emergencies. (New HOD Policy)
18

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

Received: 4/13/26

RELEVANT AMA POLICY

Hospital Disaster Plans and Medical Staffs H-225.941

1. Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-26)

Introduced by: Virginia

Subject: Protecting Mental Health Treatment Privacy in Legal Proceedings

Referred to: Reference Committee B

1 Whereas, the Medical Society of Virginia’s SafeHaven program was established in 2020 and
2 provides a confidential resource for healthcare professionals to seek mental health treatment
3 without fear of professional repercussions; and
4

5 Whereas, the confidentiality of mental health treatment is essential to encourage healthcare
6 professionals to seek necessary care; and
7

8 Whereas, the discoverability of mental health treatment records in civil and criminal trials may
9 deter individuals from seeking treatment due to concerns about privacy and legal exposure; and
10

11 Whereas, the American Medical Association has previously adopted a multitude of policies
12 supporting efforts to address issues related to career fatigue and wellness in healthcare
13 professionals and students; therefore be it
14

15 RESOLVED, that our American Medical Association develop model state legislation ensuring
16 that mental health treatment records are protected from discoverability in civil and criminal trials,
17 thereby fostering a safe and supportive environment for healthcare professionals to seek
18 necessary mental health care. (Directive to Take Action)
19

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

Received: 4/13/26

RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
 - a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
 - b. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
10. Our AMA supports physicians who are caregivers to alleviate physician burnout.

Factors Causing Burnout H-405.948

1. Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEP's Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Physician Health Programs H-405.961

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-26)

Introduced by: Mississippi

Subject: Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation

Referred to: Reference Committee B

- 1 Whereas, multiple studies show the tremendous financial and human resource burden imposed
2 upon physician practices by health insurance companies; and
3
4 Whereas, while filling medications is foundational to PDA, it does not guarantee that a patient
5 will take the medication; and
6
7 Whereas, PDA metrics cause physicians to assume more than a reasonable amount of
8 responsibility for patient behavior; and
9
10 Whereas, patient behavior regarding adherence to treatment plans is poorly controlled by
11 physicians; and
12
13 Whereas, it is unfair, burdensome, and unrealistic to continue associating PDA with physician
14 rating and compensation; therefore be it
15
16 RESOLVED, that our American Medical Association advocate against the use of patient
17 Prescription Drug Adherence (PDA) as a quality metric tied in any manner to physician ratings
18 or compensation. (Directive to Take Action)

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

Received: 4/13/26

RELEVANT AMA POLICY

D-450.958 Pain Medicine and Patient Adherence in Quality Care Assessment

1. Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys.
2. Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15 Modified: CMS Rep. 07, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-26)

Introduced by: Mississippi

Subject: Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians

Referred to: Reference Committee B

- 1 Whereas, patients can receive expensive medications much cheaper when those medications
2 are prescribed by a provider employed by a covered entity under the 340B program; and
3
4 Whereas, independent physicians are not covered entities; and
5
6 Whereas, it is favorable for patients have access to expensive medications for lower costs but
7 unfavorable that patients of independent physicians are excluded from the lower cost
8 medications; and
9
10 Whereas, this practice unfairly punishes patients of independent physicians; and
11
12 Whereas, this practice incentivizes patients to seek care from physicians and non-physician
13 prescribers employed by covered entities in lieu of independent physicians; and
14
15 Whereas, this practice unfairly places independent physicians at a disadvantage regarding
16 building and maintaining a medical practice; therefore be it
17
18 Resolved, that our American Medical Association advocate for the patients of any physician
19 practicing in the same county (or equivalent region) that contains a covered 340B entity to
20 receive reduced cost medications under the 340b program through the covered entity's
21 contracted pharmacy. (Directive to Take Action)
22

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

Received: 4/13/26

RELEVANT AMA POLICY

H-110.985 340 B Drug Discount Program

Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices; and (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. [Res. 255, A-18 Appended: BOT Rep. 08, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-26)

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

Subject: Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding

Referred to: Reference Committee B

1 Whereas, The National Institutes of Health (NIH) supports medical investigations that translate
2 into life-saving treatments, providing the foundation for 99.4% of new treatments approved by
3 the Food and Drug Administration between 2010 and 2019, and directly impacting patient care,
4 clinical practice, and public health nationwide;¹ and

5
6 Whereas, our American Medical Association (AMA) has continuously championed the necessity
7 of robust NIH funding;² and

8
9 Whereas, the AMA has engaged in strong federal advocacy to protect this enterprise, including
10 sending a July 2025 letter to Congressional leadership warning that proposed funding cuts and
11 radical reorganizations of the NIH would have serious consequences for the health of the
12 American people and local economies;² and

13
14 Whereas, a new administrative framework termed "Gold Standard Science" has been utilized to
15 abruptly terminate hundreds of active grants deemed misaligned with newly defined agency
16 priorities;³ and

17
18 Whereas, between February 28 and April 8, 2025, the NIH terminated 694 active grants
19 cumulatively valued at \$1.81 billion, and the NIH Director has indicated that previously
20 reinstated grants will face non-renewal during the 2026 cycle if they do not conform to these
21 ideological priorities;⁴ and

22
23 Whereas, these abrupt mid-project terminations disrupted approximately 1 in 30 active clinical
24 trials nationwide, halting 383 clinical studies (3.5% of actively recruiting trials) and directly
25 affecting more than 74,000 participants;⁵ and

26
27 Whereas, canceling active clinical trials for political or ideological reasons leaves enrolled
28 patients facing delayed treatments, lost access to experimental medications, or unmonitored
29 medical device implants, thereby profoundly breaching bioethical obligations to human subjects
30 and eroding public trust; and

31
32 Whereas, the federally-funded research ecosystem is facing severe liquidity constraints
33 because the White House Office of Management and Budget (OMB) missed the deadline to
34 authorize release of FY 2026 funds to the NIH, preventing spending on essential expenses
35 (e.g., salaries) and preventing disbursement of newly appropriated research capital;⁶ and

36
37 Whereas, in the 12-month period ending in June 2025, U.S. academic institutions were awarded
38 nearly \$5 billion less in NIH research grants compared to the prior year as a result of systemic
39 disruptions and slowdowns in the federal grant awarding process;⁷ and

1 Whereas, these disruptions have persisted into the current cycle, with the NIH awarding only
2 1,189 new and competitive renewal grants this fiscal year through early March 2026, a drastic
3 reduction from the 2,322 grants awarded during the same period last year, and 74% fewer
4 grants than in FY 2021-2024, despite Congress enacting increased funding for the NIH;^{8,9} and
5

6 Whereas, administrative mandates forcing the "forward-funding" or "front-loading" of multi-year
7 NIH grants, a practice requiring the agency to distribute the entire multi-year grant value upfront
8 out of a single year's appropriation, mathematically starve the pipeline of new clinical trials,
9 resulting in 5,564 fewer grants funded in FY 2025 and driving down overall grant success rate to
10 a historic low of ~17%;¹⁰ and
11

12 Whereas, the AMA joined over 40 physician organizations in an March 2025 letter sounding the
13 alarm that the unilateral implementation of a strict 15% cap on indirect (Facilities and
14 Administrative) costs will inflict "profound and generational" damage on scientific progress by
15 severely underfunding the essential infrastructure, equipment, and compliance personnel
16 necessary to responsibly conduct medical studies;¹¹ and
17

18 Whereas, this arbitrary cap, which replaces actual historical averages of 38% to 39%, is
19 projected to reduce federal funding to academic institutions by \$5.24 billion annually, causing an
20 estimated \$6.1 billion decrease in the United States Gross Domestic Product (GDP) and
21 creating massive operational deficits that threaten active clinical trials;¹ therefore be it
22

23 RESOLVED, that our American Medical Association amend Policy D-460.960 by addition and
24 deletion to read as follows:

25 2. Our AMA advocates against reorganization, consolidation or re-prioritization of the NIH when
26 such action:

- 27 a. lacks transparency or is implemented without meaningful input from the biomedical
28 research and physician communities; and
- 29 b. results in a reduction of funding that jeopardizes ongoing or long-term research through
30 premature cancellation of grants, contracts, or programs essential to public health,
31 biomedical innovation, or patient care; and
- 32 c. is driven by frameworks that bypass validated, merit-based scientific peer-review
33 processes or violate ethical obligations to human subjects. (Modify Current HOD Policy);
34 and be it further
35

36 RESOLVED, that our AMA advocate for the immediate approval of the NIH spend plan and the
37 full apportionment of congressionally appropriated funds by the Office of Management and
38 Budget (OMB), and advocate against any future use of administrative apportionment delays to
39 artificially restrict or impound biomedical research funding (Directive to Take Action); and be it
40 further
41

42 RESOLVED, that our AMA advocate against the mandatory "forward-funding" or "front-loading"
43 of multi-year NIH grants, which is the practice of distributing the entire multi-year total value of a
44 grant upfront out of a single fiscal year's limited appropriation rather than the historical practice
45 of disbursing annual grant allowances from the appropriations of those individual years, to
46 prevent drastic reductions to the total number of potential new grants and clinical trials that can
47 be awarded (Directive to Take Action); and be it further
48

49 RESOLVED, that our AMA reaffirm Policy D-460.961, which opposes arbitrary and unilateral
50 caps on indirect costs in federal grants. (Directive to Take Action)
51

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

Received: 4/14/26

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2. Mukkamala, B. "Slashing NIH funding imperils the foundation of medical research," *AMA News Wire* (August 1, 2025).
3. "Leading in Gold Standard Science: An NIH Implementation Plan," National Institutes of Health (August 22, 2025).
4. "NIH Terminates 694 Grants Worth \$1.81 Billion," *HealthDay* (May 8, 2025).
5. "NIH Grant Terminations Disrupt 1 in 30 Clinical Trials," *AJMC / JAMA Internal Medicine* (November 17, 2025).
6. "NIH funding in limbo as OMB misses 30-day deadline and what it means for your grants," *R&D World* (March 5, 2026).
7. "Clinical trials and training stalled as billions in NIH funds sit idle," *AAMC* (August 15, 2025).
8. "Despite boosted funding, NIH still slow to award grants," *Fierce Biotech* (March 16, 2026).
9. "NIH grant awards are again lagging far behind historical averages, analysis shows," *STAT* (March 17, 2026).
10. Rock-Torcivia, J. "The end of the payline: What the NIH's new funding model means for your lab," *R&D World* (March 10, 2026).
11. Lubell, J. "Cap on NIH research grants would leave 'generational' damage," *AMA News Wire* (April 2, 2025).

RELEVANT AMA POLICY

H-460.930 Importance of Clinical Research

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA encourages and supports development of community and practice-based clinical research networks. [CSA Rep. 2, I-96 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CME Rep. 4, I-08 Modified: CSAPH Rep. 01, A-18]

D-460.960 Opposing Unwarranted National Institutes of Health Research Institute Restructuring

1. Our American Medical Association advocates for an independent NIH reorganization advisory commission composed of interested parties, including physicians, scientists, researchers, academics, and patient advocacy organizations, to ensure that any proposed restructuring of the NIH is guided by medical, scientific, and public health expertise and serves the best interests of patients and the scientific community
2. Our AMA advocates against reorganization or consolidation of the NIH when such action:
 - a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
 - b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care.
3. Our AMA supports study of the short- and long-term impacts of federal biomedical research funding reductions, including medical innovation, the healthcare workforce, medical education, public health and local economies and communities.
4. Our AMA publicly opposes the reduction of research funding and funding opportunities from the NIH. [Res. 219, A-25]

D-460.961 NIH Grant Funding for Medical Research

1. H-460.973 Protection of Scientific Freedom from Special Interest Groups Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to oppose arbitrary and unilateral caps on indirect costs, including facilities and administrative reimbursements, in federal grants (including NIH grants and other governmental funding agencies) or any funding policy that restricts critical early-stage and independent research as well as grant-funded training programs.
2. Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to protect the ability of research institutions to negotiate indirect cost rates to ensure the sustainability of federally funded biomedical research.
3. Our AMA will advocate for targeted reforms to streamline administrative and regulatory requirements in order to achieve sustainable cost reductions while preserving essential research infrastructure. [Res. 502, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-26)

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

Subject: Prohibiting Pharmacy Benefit Managers from Owning Pharmacies

Referred to: Reference Committee B

1 Whereas, pharmacy benefit manager (PBM) practices harm patients by raising patient costs,
2 limiting access to necessary medications, and threatening the viability of independent
3 pharmacies, increasing pharmacy deserts^{1, 2}; and
4

5 Whereas, PBMs steer patients toward pricier drugs and charge steep markups on what would
6 otherwise be inexpensive medicines. and extract billions of dollars in hidden fees from patients,
7 pharmacists, and health systems¹; and
8

9 Whereas, PBMs frequently push higher-priced medications even when an inexpensive generic
10 of a drug is available. PBMs sometimes have a financial reason to push patients to take a more
11 expensive brand-name product. The higher the original sticker price, the larger the discounts the
12 PBMs can demand, even if the ultimate discounted price of the brand-name drug remains
13 higher than the cost of the generic³; and
14

15 Whereas, mergers and buyouts have concentrated 80 percent of the industry into the hands of
16 three major players: CVS Caremark, owned by CVS Health; Express Scripts, owned by Cigna;
17 and Optum Rx of United Health Group, minimizing any competition⁴; and
18

19 Whereas, in 2025, Arkansas passed legislation placing limits on PBMs' ability to own, manage,
20 or control pharmacies⁵ and Louisiana passed legislation increasing regulations on how PBMs
21 operate⁶; and currently, Arizona, Tennessee, and Oklahoma are considering legislation that
22 would prohibit PBMs from owning or holding, directly or indirectly, pharmacy permits in the
23 states⁷; therefore be it
24

25 RESOLVED, that our American Medical Association develop model state legislation
26 empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs)
27 and prevent PBMs from owning or operating pharmacies. (Directive to Take Action)
28

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

Received: 4/14/26

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2. <https://www.warren.senate.gov/newsroom/press-releases/warren-hawley-harshbarger-auchincloss-introduce-bipartisan-bill-to-cut-drug-costs-rein-in-pharmacy-benefit-managers-pbms>
3. <https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending>
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6. <https://www.legis.la.gov/legis/ViewDocument.aspx?d=1401324>
7. <https://www.quarles.com/newsroom/publications/state-legislative-trends-restricting-pbm-ownership-of-pharmacies>

RELEVANT AMA POLICY

D-120.919 Pharmacy Benefit Manager (PBM) Divestiture and Transparency

1. Our American Medical Association will work with appropriate parties to support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership by insurance companies.
2. Our AMA will work with appropriate parties to support and lobby for divestment of PBMs from owning affiliate pharmacies and infusion centers. [Res. 210, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-26)

Introduced by: New York

Subject: Medical Student Loans Should Not Be Capped

Referred to: Reference Committee B

1 Whereas, the H. R. 1 - One Big Beautiful Bill Act restricts medical school debt starting July 1,
2 2026, capping unsubsidized loans at \$50,000 annually with a cap of \$200,000, ending the
3 unlimited Grad PLUS program, and imposing a new lifetime cap of \$257,500 across all higher
4 education; and

5
6 Whereas, costs of attending medical school can exceed \$300,000, and the lack of federal loans
7 will force students to rely on private loans with higher interest rates and less flexible terms; and

8
9 Whereas, these changes will disproportionately affect minority and low-income students and
10 worsen physician shortages; and

11
12 Whereas, these restrictions come in addition to new conditions on the Public Service Loan
13 Forgiveness program, which enables healthcare workers to work in high-need areas to erase
14 debt over a decade; and

15
16 Whereas, the default rate for physicians is very low, approximately 5%; therefore be it

17
18 RESOLVED, that our American Medical Association oppose the caps on medical student debt
19 as a result of the H. R. 1 - One Big Beautiful Bill Act. (New HOD Policy)

20
Fiscal Note: Minimal – less than \$5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-26)

Introduced by: New York

Subject: Oppose Medicare Efficiency Adjustments

Referred to: Reference Committee B

- 1 Whereas, the Centers for Medicare & Medicaid Services (CMS) released its 2026 Medicare
2 Physician Payment Schedule (PFS) and included a new number called an efficiency
3 adjustment; and
4
5 Whereas, CMS applied this efficiency adjustment of a 2.5 percent decrease to work RVUs and
6 physician intra-service time for most services on the assumption that physicians have gained
7 efficiency in providing them, excluding time-based services such as E/M; and
8
9 Whereas, CMS claims to use the Medicare Economic Index (MEI) to determine this number, yet
10 physicians do not receive MEI-based updates; and
11
12 Whereas, CMS ignores extensive data collection that could be used, instead relying on flawed
13 physician surveys to estimate physician time; therefore be it
14
15 RESOLVED, that the American Medical Association support all efforts, whether by legislation or
16 regulation, to restrict the use of arbitrary new factors such as the efficiency adjustment used in
17 the 2026 Medicare Physician Payment Schedule. (New HOD Policy)

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

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-26)

Introduced by: New York

Subject: Protecting Healthcare as a Sensitive Location

Referred to: Reference Committee B

1 Whereas, the Medical Society of the State of New York (MSSNY) and the American Medical
2 Association (AMA) have aligned policy on healthcare as sensitive locations and protected areas
3 for everyone, including immigrants (MSSNY policy207.299; AMA policyD-160.921); and
4

5 Whereas, AMA policy opposes criminalization of medical care provided to undocumented
6 immigrant patients, including collection and reporting of immigration status or withholding of
7 federal funds (H-440.876); opposes use of medical information by immigration authorities (H-
8 7315.966); and opposes mass deportation and targeting of health care workers and medically
9 vulnerable patients based on immigration status (H-440.793); and
10

11 Whereas, there exists limited New York State guidance and limited national accreditation
12 standards for health care facilities on immigration enforcement; and
13

14 Whereas, federal immigration enforcement is increasingly undermining patient care by entering
15 health care facilities and accessing health information, and patients fearing immigration
16 enforcement's presence in healthcare facilities are less likely to go there for routine healthcare,
17 preventive care, or emergencies which leads to them presenting later and sicker and having
18 worse health outcomes; therefore be it
19

20 RESOLVED, that our American Medical Association reaffirm its policies Presence and
21 Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare (D-
22 160.921), Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant
23 Patients (H-440.876), Mass Deportation as a Public Health Issue (H-440.793), and Patient and
24 Physician Rights Regarding Immigration Status (H-315.966) (Reaffirm HOD Policy); and be it
25 further
26

27 RESOLVED that our AMA collaborate with state societies where immigration enforcement in
28 health care facility guidance has been developed, and with the AMA Advocacy Resource
29 Center, to develop model legislation and regulation for states to adopt to better protect patients
30 and health care workers from inappropriate intrusion of federal immigration agents in health
31 care facilities (Directive to Take Action); and be it further
32

33 RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies,
34 to develop health care facility standards related to immigration enforcement. (Directive to Take
35 Action)
36

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

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-26)

Introduced by: Michigan

Subject: Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs

Referred to: Reference Committee B

1 Whereas, in traditional Medicare fee-for-service, hospital care accounts for approximately 41–43
2 percent of total Medicare spending, while physician and clinical services account for
3 approximately 22–24 percent; and
4

5 Whereas, inpatient and outpatient hospital facility expenditures represent the largest single
6 driver of total cost performance within the Medicare Shared Savings Program (MSSP) and
7 materially affect shared savings and downside risk reconciliation; and
8

9 Whereas, hospital outpatient services have been among the fastest-growing components of
10 Medicare spending over the past decade, in part due to site-of-service payment differentials that
11 allow hospital outpatient departments to bill higher rates than independent physician offices for
12 comparable services; and
13

14 Whereas, under the Medicare Shared Savings Program (MSSP), total cost of care calculations
15 for an Accountable Care Organization (ACO) include all Medicare expenditures incurred by
16 ACO-assigned beneficiaries, including hospital inpatient and outpatient facility spending,
17 regardless of whether the hospital maintains a participation or financial accountability
18 agreement with the ACO contracting entity; and
19

20 Whereas, physicians participating in ACO contracting entities may be exposed to shared
21 savings reductions or downside financial risk based on hospital expenditures over which they do
22 not have direct operational or financial control; and
23

24 Whereas, hospitals that receive substantial volumes of ACO-attributed Medicare beneficiaries
25 benefit from patient flow generated through ACO care coordination efforts yet, are not uniformly
26 required to assume proportionate financial accountability for total cost performance; therefore
27 be it
28

29 RESOLVED, that our American Medical Association advocate that the Centers for Medicare &
30 Medicaid Services establish policies requiring hospitals that receive substantial expenditures
31 attributable to ACO-assigned beneficiaries to enter defined participation and financial
32 accountability agreements with the relevant ACO contracting entity (Directive to Take Action);
33 and be it further
34

35 RESOLVED, that our AMA advocate that, absent such defined participation and accountability
36 agreements, hospital expenditures for ACO-assigned beneficiaries not be included in total cost
37 of care reconciliation calculations under the Medicare Shared Savings Program or other
38 advanced alternative payment models (Directive to Take Action); and be it further

1 RESOLVED, that our AMA advocate for enhanced transparency of hospital facility spending
2 attributable to ACO-assigned beneficiaries within benchmarking and reconciliation
3 methodologies (Directive to Take Action); and be it further
4

5 RESOLVED, that our AMA to study and report on policy mechanisms to ensure equitable
6 financial accountability for hospital expenditures attributed to Medicare ACOs, including
7 mechanisms addressing site-of-service payment differentials and facility fee impacts.
8 (Directive to Take Action)
9

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

Received: 4/14/26

REFERENCES

1. Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy. March 13, 2025.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Shared Savings Program Fast Facts and Performance Year Financial Results. 2024.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-26)

Introduced by: Kansas

Subject: Opposing the Practice of Jury Anchoring in Medical Liability Cases

Referred to: Reference Committee B

1 Whereas, medical professional liability costs are increasing for physicians across the country;
2 and
3

4 Whereas, from 2013 to 2023, there was approximately a 67 percent increase in the number of
5 medical liability awards of \$10 million or more; and in 2023, 57 verdicts of \$10 million or more
6 were awarded, with more than half of these verdicts exceeding \$25 million¹; and
7

8 Whereas, these increased liability claim costs and resulting premium increases stem in part
9 from new trial tactics such as jury anchoring, in which plaintiffs' attorneys take advantage of a
10 phenomenon known as "anchor bias," whereby individuals give disproportionate weight to the
11 initial information they receive when making decisions; and
12

13 Whereas, plaintiffs' attorneys in medical liability litigation employ anchoring bias to obtain
14 outsized non-economic damage awards by requesting amounts that are not based on objective
15 evidence; and
16

17 Whereas, outsized damage awards are a major driver of medical professional liability insurance
18 claims, which in turn drive premium increases, contribute to physician shortages, and threaten
19 patient access to care; therefore be it
20

21 RESOLVED, that our American Medical Association opposes the practice of jury anchoring in
22 medical liability litigation, specifically as it related to non-economic damages. (New HOD Policy)
23

Fiscal Note: Minimal – less than \$5,000

Received: 4/14/26

REFERENCES

1. Nuclear Verdicts: How Social Inflation Impacts Physicians and Patients, Robert E. White Jr., President, The Doctors Company and TDC Group (2024). Accessible at <https://www.thedoctors.com/articles/nuclear-verdicts-social-inflation-healthcare-impact-physicians-patients>

2. Policy Research Perspectives Upward Trajectory of Medical Liability Premiums Persists for Sixth Year in a Row by Allen Hardiman, PhD (2024). Accessible at <https://www.ama-assn.org/system/files/prp-mlm-premiums-2025.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-26)

Introduced by: American College of Lifestyle Medicine

Subject: Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs

Referred to: Reference Committee B

- 1 Whereas, rural health in the United States is in crisis per decades of hospital closures, clinician
2 shortages and losses of essential services that have left millions of people without reliable
3 access to care and worsened health outcomes; and
4
- 5 Whereas, chronic challenges to providing adequate rural health were compounded by the newly
6 \$1 trillion cuts to Federal health care funding; and
7
- 8 Whereas, the Congress established the Rural Health Transformation Program (RHTP) as a
9 partial remedy for those cuts by providing \$50 billion in awards to rebuild and reshape states'
10 health care systems, not backfill...operating budgets; and
11
- 12 Whereas, the RHTP's primary objective is to "Make Rural America Healthy Again" by strategies
13 that will support rural health innovations and new access points to promote preventative health
14 and address root causes of diseases via Projects that will use evidence-based, outcomes driven
15 interventions to improve disease prevention, chronic disease management, behavioral health,
16 and prenatal care; and
17
- 18 Whereas, fifty percent of the \$50 billion must be divided equally among states with approved
19 applications (\$100 million per state per year; and the remaining 50% will be distributed by CMS
20 (\$5 billion per year) based on factors identified in the Notice of Funding Opportunity (NOFO);
21 and
22
- 23 Whereas, this funding structure ensures a minimum level of support for every participating state
24 along with a substantial discretion for the CMS to further support states whose project priorities
25 align with Federal interests; and
26
- 27 Whereas, within the NOFO, states are required to implement at least three of the ten activity
28 categories described in Section 71401. Three of these categories closely align with the
29 principles and practice of Lifestyle Medicine: (a) promoting evidence-based, measurable
30 interventions to enhance prevention and chronic disease management; (b) advancing
31 consumer-facing, technology-driven solutions for chronic disease prevention and management;
32 and (c) providing payments to health care providers for covered health care items and services;
33 and
34
- 35 Whereas, additional delineation of these categories highlights collaborative strategies for rural
36 health facilities, including: (a) advancing sustainable access through initiatives that enhance
37 practitioner efficiency, operational sustainability, and shared coordination of technology and
38 clinical services across primary, specialty, and emergency care; and (b) promoting innovative
39 care models that aim to improve health outcomes, optimize care coordination, and enable

40 flexible delivery structures, supported by payment mechanisms that align provider and
41 Accountable Care Organizations' incentives with cost reduction, quality improvement, and care
42 delivery in lower-cost settings; and
43

44 Whereas, some aspects of the current Administration's preferred policies may be acceptable to
45 healthcare systems, such as including nutrition training in continuing medical education; and
46

47 Whereas, the principles and practice of Lifestyle Medicine are grounded in evidence-based,
48 reproducible, and measurable health care, emphasizing the identification and treatment of
49 underlying drivers of chronic disease through a collaborative physician-patient partnership; and
50

51 Whereas, the principles and practices of Lifestyle Medicine seek to reduce the long-term costs
52 of care for chronic diseases through reduction of the need for medications and repetitive
53 therapies; therefore be it
54

55 RESOLVED, that our American Medical Association encourage State Constituent Medical
56 Associations to work collaboratively with their respective State Departments of Health to
57 incorporate implementation of the principles and practices of lifestyle medicine within the design
58 of their respective State's Rural Health Transformation Program, thereby satisfying some of the
59 scored requirements/categories of the Rural Health Transformation Program application (New
60 HOD Policy); and be it further
61

62 RESOLVED, that our AMA encourage State Constituent Medical Associations to work
63 collaboratively with their respective State Departments of Health to include nutrition continuing
64 medical education as an effective strategy to satisfy one of the scored requirements/categories
65 of the Rural Health Transformation Program application. (New HOD Policy)
66

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

Received: 4/15/26

REFERENCES

1. Moy E, McClellan M. The Rural Health Transformation Program—an avenue for promoting administrative policies. *N Engl J Med*. Published online 2026. Accessed April 14, 2026. <https://www.nejm.org/doi/full/10.1056/NEJMp2515454>
2. American Medical Association. What to know about a chance at \$50 billion in rural health funding. Accessed April 14, 2026. <https://www.ama-assn.org/public-health/population-health/what-know-about-chance-50-billion-rural-health-funding>
3. American College of Lifestyle Medicine. A family physician's introduction to lifestyle medicine. Supplement to *The Journal of Family Practice*. 2022. Accessed April 14, 2026. https://cdn.mdedge.com/files/s3fs-public/aclm_2022_final_set_0.pdf
4. American College of Lifestyle Medicine. Transforming rural health through lifestyle medicine. Accessed April 14, 2026. <https://lifestylemedicine.org/transforming-rural-health-through-lifestyle-medicine/>

RELEVANT AMA POLICY

H-465.994 Improving Rural Health

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

and health care services in rural communities.

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
 4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
 5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. [Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 433, A-19 Modified: CSAPH Rep. 2, A-22 Reaffirmed: CMS Rep. 09, A-23 Reaffirmed: Res. 724, A-23 Appended: Res. 919, I-24 Reaffirmed: Res. 237, I-25 Reaffirmed: CMS Rep. 03, I-25]

H-465.997 Access to and Quality of Rural Health Care

1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.
2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.[CMS Rep. G, A-87 Modified: Sunset Report, I-97 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed: CMS Rep. 1, A-21 Reaffirmed: BOT Rep. 07, I-24 Reaffirmed: CMS Rep. 03, I-25]

H-465.972 Payment Models to Sustain Rural Hospitals

1. Our American Medical Association believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to:
 - support and monitor novel payment models for rural hospitals and encourage uniform reporting; and
 - support educating patients, physicians, and non-physician practitioners on alternative payment models for rural hospitals.
2. Our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care.
3. Our AMA will work to vigorously oppose Medicaid cuts as they significantly impact at-risk rural hospitals. [CMS Rep. 03, I-25]

H-170.995 Healthful Lifestyles

The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health

lifestyles.[BOT Rep. A, NCCMC Rec. 48, A-78 Reaffirmed: CLRPD Rep. C, A-89 Res. 402, I-94
Reaffirmed: CSA Rep. 6, A-04 Reaffirmed: BOT Rep. 8, I-06 Reaffirmed: CSAPH Rep. 01, A-16]

H-425.972 Healthy Lifestyles

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.[Res. 423, A-12 Appended: Res. 959, I-17 Reaffirmed: Res. 302, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-26)

Introduced by: Ohio

Subject: Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians

Referred to: Reference Committee B

1 Whereas, effective 01/01/2026, The CY 2026 Physician Fee Schedule final rule (CMS-1832-F)
2 significantly reduced the practice expense portion of physician payments for services provided
3 in the facility setting; and
4

5 Whereas, cuts to practice expense will be destabilizing to the healthcare system, causing
6 significant disruption in access to healthcare services, particularly for those in rural and
7 underserved areas, by removing urgently needed resources from physicians; and
8

9 Whereas, many specialists are classified as “facility-based” but work as independent practices
10 or professional corporations and are not directly salaried by a hospital, as the rule suggests. As
11 a result, they incur rent for their own office space and utility expenses, employ and train
12 administrative and clinical support staff, and shoulder ongoing costs for equipment, information
13 technology, quality improvement programs, biosafety and compliance infrastructure, which
14 should be adequately compensated by CMS; and
15

16 Whereas, independent physician groups operate around the country, tending to be smaller
17 local, rural or regional groups. Groups like these are reliant on their expected venue for services
18 provided, and certainly expend significant practice expense. These physician groups do not
19 have the ability to absorb significant cuts to payments the way a large health system may be
20 able. These cuts will force many independent physician groups to sell their practices to
21 hospitals, health systems, or larger entities – in direct contradiction to CMS’ states goals¹; and
22

23 Whereas, these practice expense cuts will negatively impact all medical specialties that perform
24 services in the hospital-based setting, causing across-the-board harm to our patients and our
25 communities; therefore be it
26

27 RESOLVED, that our American Medical Association write and promote federal legislation to
28 reverse CY 2026 Physician Fee Schedule (CME-1832-F) reductions to facility-based practice
29 expenses payments for physicians – retroactive to 01/01/2026 – and codify future payment
30 updates by linking these payments to the Medicare Economic Index (MEI). (Directive to Take
31 Action)

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

Received: 4/15/26

REFERENCES

1. <https://www.hospitalmedicine.org/letters/shm-leads-multispecialty-effort-to-stop-facility-based-practice-expense-cuts/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-26)

Introduced by: American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Pediatrics, Minnesota Medical Association

Subject: Universal Newborn Congenital Cytomegalovirus Screening

Referred to: Reference Committee B

1 Whereas, congenital Cytomegalovirus (cCMV) is the leading cause of non-genetic birth defects
2 in the United States, and can cause sensorineural hearing loss, lasting seizure disorders, and
3 other developmental disorders; and
4
5 Whereas, roughly one in every 200 United States newborns have cCMV, most are
6 asymptomatic at birth, and 2,230 infants develop sensorineural hearing loss annually; and
7
8 Whereas, cCMV must be diagnosed within the first 21 days of life to distinguish it from postnatal
9 CMV infection, which is not associated with hearing loss or other developmental disorders; and
10
11 Whereas, the American Academy of Otolaryngology – Head and Neck Surgery supports
12 universal newborn cCMV screening;¹ and
13
14 Whereas, Minnesota and Connecticut have adopted universal newborn cCMV screening; and
15
16 Whereas, many cCMV positive newborns who are asymptomatic at birth develop late-onset
17 hearing loss;^{2,3} and
18
19 Whereas, children with late-onset hearing loss have a mean age of detection of 27 months; and
20
21 Whereas, the critical age for intervention in childhood hearing loss, including speech and
22 language services and amplification, is prior to age 18-20 months; and
23
24 Whereas, after Minnesota implemented universal cCMV screening, the time of first audiology
25 visit dropped from 8.5 months of age to roughly 25 days of age on average, and the number of
26 diagnoses jumped from about 3 per year to 61 per year;⁴ and
27
28 Whereas, early detection of cCMV offers the option of antiviral therapy, which has been
29 associated with a decrease in severity and a delay in the progression of hearing loss; therefore
30 be it
31
32 RESOLVED, that our American Medical Association support state legislation and policies
33 requiring universal newborn screening for congenital cytomegalovirus (cCMV) (New HOD
34 Policy); and be it further

- 1 RESOLVED, that our AMA support federal legislation and policies that expand newborn
- 2 screening for congenital cytomegalovirus (cCMV) and increase funding for public awareness,
- 3 prevention, and research related to congenital cytomegalovirus infection. (New HOD Policy)

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

Received: 4/15/26

REFERENCES

1. American Academy of Otolaryngology – Head and Neck Surgery position statement: Universal newborn congenital cytomegalovirus screening. <https://www.entnet.org/resource/universal-newborn-congenital-cytomegalovirus-ccmv-screening/>
2. Rohren L, Shanley R, Smith M, Yue M, Huang TC, Nelson P, Hernandez-Alvarado N, Schleiss MR, Gravel KE. Congenital Cytomegalovirus-Associated Sensorineural Hearing Loss in Children: Identification Following Universal Newborn Hearing Screening, Effect of Antiviral Treatment, and Long-Term Hearing Outcomes. *Ear Hear.* 2024 Jan-Feb 01;45(1):198-206. doi: 10.1097/AUD.0000000000001411. Epub 2023 Aug 11. PMID: 37563758; PMCID: PMC10718220.
3. Richard, C., Shakhtour, L., Gallo, N., Smith, R., MacDonald, C.B., Gentry, R., Scheerer, H., Arnold, S.R. and Carrillo-Marquez, M.A. (2025), Audiological Outcomes of Cytomegalovirus Saliva PCR-Positive Newborns in Support of Universal Screening. *Otolaryngol Head Neck Surg*, 173: 1245-1253. <https://doi.org/10.1002/ohn.1332>
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RELEVANT AMA POLICY

H-245.970 Early Hearing Detection and Intervention

1. Our AMA supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner.
2. Our AMA supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-26)

Introduced by: Georgia

Subject: Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage

Referred to: Reference Committee B

- 1 Whereas, Medicare is a critical federal program that provides health insurance coverage to over
2 60 million Americans, including seniors and individuals with disabilities; and
3
- 4 Whereas, beneficiaries currently have the option to enroll in either Traditional Medicare (Parts A
5 and B) or a Medicare (Dis)Advantage (Part C) plan offered by private insurers, allowing them to
6 choose the coverage that best meets their individual health and financial needs; and
7
- 8 Whereas, the right of beneficiaries to choose between Traditional Medicare and Medicare
9 Advantage should be preserved; and
10
- 11 Whereas, the right of beneficiaries to change their coverage from time to time should be more
12 seamless, readily identifiable, and flexible; and
13
- 14 Whereas, any efforts to limit or restrict access to either form of coverage—Traditional Medicare
15 or Medicare Advantage—may undermine the principles of patient autonomy, equity, and access
16 to care; and
17
- 18 Whereas, both Traditional Medicare and Medicare Advantage have unique benefits and
19 limitations, and no single option is perfect for each patient; and
20
- 21 Whereas, AMA Policy H-330.878 supports Medicare plans that provide at a minimum all part A
22 and B original services and advocates for better regulation and transparency on websites as
23 well as maintaining publicly valuable databases of doctors in network; and
24
- 25 Whereas, AMA Policy H-285.902 urges CMS to ensure directory accuracy yearly and any
26 significant changes as well as conduct reviews and reports to Medicare plan finder with penalty
27 for failure to do so as well as adequacy of network both in ration of members to specialty and
28 subspecialty as well as distances to specialty as CMS currently uses; and
29
- 30 Whereas, AMA Policy H-330.913 opposes bait and switch tactics of Medicare advantage plans
31 whereby patients' and physicians' participation is based on a payment schedule (that often
32 changes) which may result in physicians leaving the network while continuing to capture
33 covered patients, thereby necessitating their identification of new in-network physicians; and
34
- 35 Whereas, AMA Policy D-330.930 acknowledges that Medicare Advantage plans may be
36 misleading in their marketing and advertising concerning the lack of secondary coverages
37 (Medigap policy) with Medicare Advantage plans and supports ongoing outreach and education
38 efforts to raise public awareness and ensure equitable access; and

39 Whereas, the current Medicare enrollment process is fragmented across multiple platforms,
40 private brokers, and marketing channels, creating confusion for beneficiaries attempting to
41 compare coverage options; and

42

43 Whereas, unlike the Affordable Care Act marketplace administered through HealthCare.gov,
44 Medicare lacks a single, unified, official online platform that presents standardized, neutral, and
45 easily understandable plan comparisons¹; and

46

47 Whereas, Medicare beneficiaries—particularly seniors and individuals with disabilities—are
48 frequently targeted by aggressive telemarketing and third-party marketing organizations that
49 may present biased or incomplete information²; and

50

51 Whereas, Medicare.gov currently operates the “Medicare Plan Finder” which allows
52 beneficiaries to compare and shop for private Medicare Advantage plans and stand-alone Part
53 D plans, however the most recent update in 2025 frequently produced erroneous and conflicting
54 information about which providers were in network³; and

55

56 Whereas, the collection and dissemination of beneficiary data by third-party marketing entities
57 raises significant concerns regarding privacy, security, and unauthorized solicitation, and
58 equitable access to Medicare information requires robust outreach and education for rural,
59 underserved, elderly, disabled, and technologically disadvantaged populations; therefore be it

60

61 RESOLVED, that our American Medical Association advocate for the development and
62 maintenance overseen by the Centers for Medicare & Medicaid Services of a centralized, official
63 Medicare enrollment platform that provides clear, neutral, accurate, and easily understandable
64 comparisons of coverage options under Traditional Medicare, Medicare Advantage, and
65 supplemental coverage, including information on provider networks, prior authorization
66 requirements, benefits, and out-of-pocket costs (Directive to Take Action); and be it further

67

68 RESOLVED, that our AMA advocate for ongoing oversight and evaluation of such platform to
69 ensure the accuracy of plan and directory information, neutrality, usability, accessibility, and
70 protection of beneficiaries from deceptive or coercive practices (Directive to Take Action); and
71 be it further

72

73 RESOLVED, that our AMA advocate for federal policies that prohibit telemarketing firms and
74 third-party marketing organizations from directly enrolling Medicare beneficiaries, and instead
75 require that beneficiaries be directed to the official Medicare enrollment platform for plan
76 enrollment (Directive to Take Action); and be it further

77

78 RESOLVED, that our AMA advocate for robust privacy and data security safeguards, including
79 disclosure of data breaches, within any official Medicare enrollment platform, including
80 protections against unauthorized access, misuse, or commercial exploitation of beneficiary
81 information and prohibitions on the sale, transfer, or sharing of beneficiary enrollment data with
82 third parties for commercial purposes (Directive to Take Action); and be it further

83

84 RESOLVED, that our AMA advocate for comprehensive outreach, education, and accessibility
85 initiatives to ensure that beneficiaries and physicians, including those in rural, elderly, disabled,
86 underserved, and technologically disadvantaged populations, can effectively use the official
87 Medicare enrollment platform (Directive to Take Action); and be it further

88 RESOLVED, that our AMA oppose legislative, regulatory, or administrative actions that would
89 reduce access to, limit funding for, or otherwise disadvantage either Traditional Medicare or
90 Medicare Advantage. (New HOD Policy)

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

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-26)

Introduced by: Georgia

Subject: Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations

Referred to: Reference Committee B

- 1 Whereas, the use of artificial intelligence (AI), algorithms, and predictive analytics by health
2 insurers and utilization review entities is rapidly expanding in both coverage determinations
3 (including prior authorization and claims adjudication) and health insurance eligibility and
4 underwriting decisions affecting applicants; and
5
- 6 Whereas, emerging state frameworks, including Georgia Senate Bill 444 (2026) recently passed
7 by the Georgia Legislature, recognize that AI may serve as a clinical decision-support tool but
8 must not replace independent human clinical judgment; and
9
- 10 Whereas, reliance on AI as the sole basis for adverse determinations—including denial of
11 coverage, limitation of benefits, or denial or restriction of health insurance eligibility for
12 applicants—risks inappropriate, non-individualized decision-making and may exacerbate
13 inequities; and
14
- 15 Whereas, health insurance applicants and insured patients are frequently unaware when AI
16 tools are used in eligibility, underwriting, or coverage determinations and are not provided
17 meaningful explanations of how such tools influence decisions; and
18
- 19 Whereas, current processes often lack timely access to qualified human review, including
20 physician review when clinical issues are implicated, particularly by professionals in the same
21 specialty; and
22
- 23 Whereas, AI systems used in insurance eligibility, underwriting, and coverage determinations
24 may introduce or perpetuate bias, opacity (“black box” decision-making), and variability in
25 performance, without standardized requirements for auditability, validation, or regulatory
26 oversight; and
27
- 28 Whereas, the absence of clear national standards for AI-assisted eligibility and coverage
29 determinations creates inconsistent protections across states, markets, and payer types,
30 including individual market applicants, employer-sponsored plans, and Medicare Advantage;
31 and
32
- 33 Whereas, while AMA Policy H-480.940 establishes broad principles for augmented intelligence
34 in health care, it does not specifically address payer use of artificial intelligence in insurance
35 underwriting, eligibility determinations, applicant denial processes, required human review,
36 applicant appeal rights, or regulatory safeguards governing adverse insurance decisions
37 generated by AI systems; and

38 Whereas, physicians are ethically obligated to advocate for patients' access to medically
39 necessary care and to oppose barriers created by non-transparent utilization management or
40 underwriting practices; and

41
42 Whereas, due process protections—including transparency, explanation of decisions, and
43 meaningful opportunities for appeal or reconsideration—are essential to safeguard both
44 patients' access to medically necessary care and applicants' fair access to health insurance
45 coverage; therefore be it

46
47 RESOLVED, that our American Medical Association oppose the use of artificial intelligence,
48 algorithms, or automated decision-making systems as the sole basis for any adverse health
49 insurance determination, including denials, delays, or limitations of coverage and adverse
50 eligibility, underwriting, or enrollment determinations affecting health insurance applicants or
51 insured patients (New HOD Policy); and be it further

52
53 RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-
54 making systems are used in adverse health insurance determinations, any required human
55 review must be conducted through the independent judgment of a licensed physician in
56 accordance with existing AMA peer review policy, and must not be overridden, dictated, or
57 unduly influenced by the output of such systems (Directive to Take Action); and be it further

58
59 RESOLVED, that our AMA advocate for policies requiring that patients and physicians be
60 provided a clear and accessible explanation when artificial intelligence or automated decision-
61 making systems materially contributed to an adverse health insurance determination, including
62 an explanation of the role of the system in the decision, in both coverage determinations and
63 eligibility, underwriting, or enrollment decisions (Directive to Take Action); and be it further

64
65 RESOLVED, that our AMA support and advocate for payer-specific regulatory standards
66 governing the use of artificial intelligence and automated decision-making systems in adverse
67 health insurance determinations, including requirements for auditable records of AI-assisted
68 decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and
69 oversight by appropriate regulatory bodies (Directive to Take Action); and be it further

70
71 RESOLVED, that our AMA advocate for the uniform application of safeguards governing
72 artificial intelligence and automated decision-making systems across all payer types and
73 markets, including commercial insurance, individual and small-group markets, employer-
74 sponsored coverage, and government insurance, with particular attention to applicant-facing
75 eligibility, underwriting, and enrollment decisions. (Directive to Take Action)

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

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-26)

Introduced by: Indiana

Subject: Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms

Referred to: Reference Committee B

1 Whereas, Indiana law defines an “urgent care facility”¹ as a freestanding facility that provides
2 walk-in, episodic care for acute but non-life-threatening conditions, and specifically excludes
3 hospital emergency departments from being classified as urgent care facilities under Indiana
4 Code § 16-24.5-1-1; and

5
6 Whereas, there is currently no Indiana statute or Indiana Department of Health regulation
7 requiring urgent care centers to post signage stating that they are not emergency rooms, which
8 may contribute to patient confusion, particularly during urgent medical situations¹; and

9
10 Whereas, the absence of clear signage distinguishing urgent care clinics from emergency
11 departments may lead patients experiencing medical emergencies to mistakenly seek care at
12 an urgent care center, potentially delaying necessary emergency treatment³; and

13
14 Whereas, several other states, including Texas and Colorado^{2, 3, 4, 5, 6, 7}, have adopted laws
15 requiring freestanding emergency departments to post explicit signage identifying their
16 emergency status and prohibiting the misuse of the term “emergency” by non-emergency
17 providers; and

18
19 Whereas, Indiana’s current transparency law for urgent care centers, enacted in 2020, requires
20 disclosure of service prices on websites but does not address physical signage or language use
21 that distinguishes urgent care centers from emergency departments; and

22
23 Whereas, greater signage transparency would empower patients to make informed decisions
24 about where to seek care and reduce the risk of inappropriate facility use during a medical
25 emergency; therefore be it

26
27 RESOLVED, that our American Medical Association advocate for federal regulatory or
28 legislative action that would require clear and standardized signage for urgent care centers to
29 distinguish them from hospital emergency departments. (Directive to Take Action)

30
Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-26)

Introduced by: Indiana

Subject: Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients

Referred to: Reference Committee B

1 Whereas, patients residing in nursing homes often present with complex, chronic medical
2 conditions requiring specialized care beyond primary services; and
3

4 Whereas, nonphysician practitioners (NPPs), such as nurse practitioners and physician
5 assistants, play a critical role in extending access to care in long-term care settings; and
6

7 Whereas, the delegation of care to NPPs without appropriate physician oversight may result in
8 variability in the quality, accuracy, and complexity of care provided to medically fragile patients;
9 and
10

11 Whereas, the involvement of a board-certified medical specialist in a patient's ongoing care plan
12 ensures alignment with evidence-based practices, appropriate diagnostic assessments, and
13 continuity of specialty care; and
14

15 Whereas, current CMS guidelines require primary care physicians to alternate face-to-face visits
16 with non-physician practitioners for nursing home patients, yet no such requirement exists for
17 medical specialists overseeing similar care; therefore be it
18

19 RESOLVED, that our American Medical Association support federal legislation or regulation to
20 require a minimal standard for specialist care for patients in nursing homes, such that, when a
21 board-certified medical specialist delegates visits to nonphysician practitioners in a nursing
22 home setting, the physician specialist must personally conduct a face-to-face evaluation of the
23 patient either in person or via telehealth no less than every third visit. (New HOD Policy)
24

Fiscal Note: Minimal – less than \$5,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-26)

Introduced by: Academic Physicians Section

Subject: Impact of a Proposed \$100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System

Referred to: Reference Committee B

1 Whereas, International Medical Graduates (IMGs) constitute twenty-five percent of the United
2 State's physician workforce¹, representing a significant and essential component, particularly in
3 specialties with critical shortages (e.g., Internal Medicine, Family Medicine, Psychiatry,
4 Pathology, and Neurology)^{6,7}, and other shortage specialties; and

5
6 Whereas, federally designated underserved areas and rural areas are more likely to be served
7 by IMGs, catering to 46 to 66 million Americans^{2,3}, and

8
9 Whereas, IMGs serve vital roles in medical education and research⁴, developing our nation's
10 future physicians and health professionals as faculty members, researchers and preceptors in
11 medical schools and training programs across the country; and

12
13 Whereas, many non-U.S. physicians who graduated from international and U.S. medical
14 schools rely on non-immigrant employment-based visa programs in order to participate in
15 graduate medical education⁵, and subsequently practice medicine in the underserved areas; and

16
17 Whereas, proposals to substantially increase employment-based visa fees, as high as
18 \$100,000, has posed an unprecedented financial barrier for institutions;^{1,2} sponsoring visa for
19 these individuals; and

20
21 Whereas, employment-based visa fees could disproportionately limit access to residency
22 training opportunities for qualified applicants; and

23
24 Whereas, employment-based visa fees could sharply increase the vacancy rate within residency
25 programs and undermine teaching hospitals' capacity⁷ for providing clinical training and safety-
26 net care to underserved populations; and

27
28 Whereas, the 2026 National Resident Matching Program (NRMP) Match cycle and the following
29 waiver employment cycle would be the first major residency recruitment cycle, and the
30 underserved area physician employment cycles potentially affected by implementation of such a
31 visa fee; and

32
33 Whereas, no formal national analysis has been conducted to evaluate the potential impact of
34 such a fee on IMGs participation in the Match, residency program recruitment, or physician
35 workforce supply in underserved areas^{11,12}; therefore be it

36
37 RESOLVED, that our American Medical Association, in conjunction with other key
38 organizations, study the potential impact of a proposed \$100,000 employment-based visa fee
39 on:

- 1 • International Medical Graduates participation in the National Resident Matching
- 2 Program (NRMP) Match; and
- 3 • Graduate medical education programs; and
- 4 • Critical access hospitals; and
- 5 • Waiver and non-waiver recruitment into all specialties; and
- 6 • Physician workforce development and access to care in communities across all 50
- 7 states and U.S. territories.

8 (Directive to Take Action)

9

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

Received: 4/15/26

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RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
 - a. completion of medical school and residency training outside the U.S.;
 - b. extensive U.S. medical practice; and
 - c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
 - a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
 - b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
 - c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
 - d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the

- quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
 22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
 23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
 24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
 25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
 26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training. [BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23; Reaffirmed: Res. 312, A-25; Reaffirmed in lieu of the first resolve: Res. 234, A-25]

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

Protection for International Medical Graduates H-255.960

Our American Medical Association supports relevant interested parties in developing a confidential mechanism through which physicians can report workplace immigration related interviews, in order to identify and address potential instances of unfair treatment or targeting of international medical graduate physicians. [Res. 234, A-25]

Physician Visa Protection and Pathway to U.S. Permanent Residency D-255.967

1. Our American Medical Association advocates for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.
2. Our AMA advocates for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.
3. Our AMA advocates for the creation of a dedicated visa pathway specifically for physicians. [Res. 213, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-26)

Introduced by: California, Hawaii, Idaho, Oregon, Washington, Wyoming

Subject: Standby Capacity Payments and Health IT for Hospitals in Rural Areas

Referred to: Reference Committee B

1 Whereas, rural communities already suffering from physician shortages, hospitals closures, less
2 health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality
3 are at even greater risk with the significant \$1 trillion in Medicaid and Affordable Care Act (ACA)
4 funding cuts (CBO) recently imposed by Congress through the passage of H.R. 1; and
5

6 Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation
7 Program that provides \$50 billion to states to address rural health care challenges; and
8

9 Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA
10 10 or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage
11 nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural
12 physicians and communities is even greater; and
13

14 Whereas, while the AMA has extensive policy on improving rural health provider shortages
15 infrastructure, health care disparities, and access to care, this resolution includes additional
16 specific policies that are warranted to augment AMA's rural health advocacy; and
17

18 Whereas, 54% of rural residents report that access to medical specialists is a problem in their
19 19 community and telehealth has helped to address some physician shortages, provide access
20 to specialty care, and reduce patient burden of traveling long distances to receive care; and
21

22 Whereas, rural hospitals that have difficulty retaining subspecialists have developed telehealth
23 programs in coordination with larger urban hospitals that allow them to consult on patient care
24 as needed and treat complex patients at local facilities - helping patients avoid the cost and time
25 associated with traveling long distances to larger medical centers; and
26

27 Whereas, a GAO analysis found that the availability of health care providers in counties with
28 rural hospital closures was lower and declined more over time when compared to counties
29 without rural hospital closures and a Health Affairs study found that the availability of physicians
30 and the viability of hospitals are related which makes the argument that more should be done to
31 sustain rural physician practices to protect the entire health care system in rural areas; and
32

33 Whereas, there is evidence that administrative requirements, which are a challenge for
34 physicians regardless of setting, can impose additional challenges for physicians in rural areas
35 such as a 2018 GAO study of Medicare quality improvement programs that found small and
36 rural practices were more likely to receive a negative payment adjustment citing lack of
37 technology, financial resources to hire staff to manage the programs, and limited capacity to
38 monitor program requirements which ultimately led to 18% of rural physician practices being
39 penalized in the Medicare quality payment program in 2022; and

1 for example, a California Department of Health Services study found that providers in rural
2 areas don't have access to basic health information technology or networks to engage in data
3 exchange and while there is wide adoption of EHRs among physicians, physicians who had not
4 adopted EHRs were more likely to be in rural or solo practice; and
5

6 Whereas, more than half of current rural hospitals in the United States lack a maternity ward
7 and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than
8 700 rural hospitals in 2025 were at risk of closure due to financial problems; and
9

10 Whereas, hospital administrators cite a number of reasons for the closures, including high costs,
11 labor shortages, low public and private reimbursement, and declining birth rates. Labor and
12 delivery units are one of the most expensive departments for hospitals to maintain, second only
13 to emergency departments; and
14

15 Whereas, a study by the American Journal of Public Health that looked at adverse maternal
16 outcomes in rural and urban areas across the country found that pregnant individuals residing in
17 rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal
18 mortality rates almost twice the rate of individuals in urban areas; and
19

20 Whereas, a CHQPR study shows that half of the patients in rural hospitals have private
21 insurance and in most cases it is the amount that private insurance pays, not Medicaid that
22 determines whether a rural hospital loses money. To preserve and enhance essential hospital
23 services in rural areas, CHQPR recommends that small rural hospitals receive Standby
24 Capacity Payments from both public and private payers to cover the hospital's fixed costs for
25 maintaining essential services and access to necessary care; therefore be it
26

27 RESOLVED, that our American Medical Association assist state medical associations, specialty
28 societies and physician practices with the implementation of H.R. 1, to mitigate the negative
29 impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in
30 rural areas (Directive to Take Action); and be it further
31

32 RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual
33 telehealth consultations as an option to increase access to primary and specialty care in rural
34 communities, acknowledging that significant investments in rural telehealth broadband must be
35 made in order to effectively deliver telehealth services (New HOD Policy); and be it further
36

37 RESOLVED, that our AMA encourage the development of programs and financial assistance
38 models for rural physician practices in need of health information technology and other
39 technological modernization and security, as well as access to specialty equipment to provide
40 quality care (New HOD Policy); and be it further
41

42 RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to
43 provide funding for standby capacity payments to sustain obstetric services at hospitals at risk
44 of closing access to maternity care. (New HOD Policy)
45

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

Received: 4/15/26

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RELEVANT AMA POLICY

D-190-969 Rural Hospital Payment Models

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
 2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).
- D-465.994 New Reimbursement System Needed for Rural Hospital Survival
- Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

H-200.972 Primary Care Providers in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
 - a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
 - b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
 - c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
 - d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
 - e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

- f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
 - g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
- a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
 - b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access

- 8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
- 9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
- 10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
- 11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

H-465.997 Access to Quality Rural Health Care

- 1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.
- 2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

H-465.998 Addressing Payment & Delivery in Rural Hospitals

- 1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
 - c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
 - f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
- 2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
- 3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-26)

Introduced by: California, Hawaii, Oregon, Washington, Wyoming

Subject: Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas

Referred to: Reference Committee B

1 Whereas, according to a 2024 National Public Radio (NPR) investigation, half of the active duty
2 U.S. military installations are located in federally designated health professional shortage areas
3 (HPSAs), including maternal care deserts and as the military has downsized and outsourced
4 health care over the last decade to private physicians and hospitals, military personnel and their
5 families cannot find physicians accepting new patients, exacerbating the health care demands
6 and access to care problems in rural areas; and
7

8 Whereas, the military is also contracting with more people to provide services on military bases,
9 such as janitorial cleaning staff, rather than hiring them as employees and many of these people
10 are low-income, uninsured women who need maternal health care but can't obtain it on or near
11 the base; and
12

13 Whereas, many states have examples of successful maternal care models, such as the
14 California Maternal Quality Care Collaborative (CMQCC) created by Stanford University School
15 of Medicine in partnership with the State of California and multiple stakeholder organizations
16 that used research, data, toolkits and outreach to reduce maternal mortality by 65% from 2006-
17 2016; and
18

19 Whereas, there is a need to creatively engage in efforts to ensure that women have access to
20 comprehensive reproductive health care and pregnant patients in rural regions have access to
21 the care necessary to ensure healthy outcomes for both baby and mother; therefore be it
22

23 RESOLVED, that our American Medical Association urge the Department of Defense to provide
24 comprehensive reproductive health care coverage, funding and improved access to labor and
25 delivery services for military personnel, military families, and non-military individuals working on
26 military bases in maternity care health professional shortages areas (Directive to Take Action);
27 and be it further
28

29 RESOLVED, that our AMA continue to research and distribute successful state and specialty
30 society models that have improved access to comprehensive reproductive care and maternal
31 care in rural areas and reduced maternal mortality rates. (Directive to Take Action)
32
33

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

Received: 4/15/26

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RELEVANT AMA POLICY

D-190-969 Rural Hospital Payment Models

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).

D-465.994 New Reimbursement System Needed for Rural Hospital Survival

Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

H-130-954 Non-Emergent Patient Transportation Systems

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

H-200.972 Primary Care Providers in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
 - a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
 - b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
 - c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
 - d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
 - e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
 - f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and

- g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
- 2. Our AMA supports efforts to:
 - a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
 - b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H-215.960 Hospital Consolidation

- 1. Our American Medical Association affirms that:
 - a. Health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs.
 - b. The AMA strongly supports and encourages competition in all health care markets.
 - c. The AMA supports rigorous review and scrutiny of proposed mergers to determine their
 - d. Antitrust relief for physicians remains a top AMA priority.
- 2. Our AMA will continue to support actions that promote competition and choice, including:
 - a. Eliminating state certificate of need laws.
 - b. Repealing the ban on physician-owned hospitals.
 - c. Reducing administrative burdens that make it difficult for physician practices to compete.
 - d. Achieving meaningful price transparency.
- 3. Our AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

H-465-981 Enhancing Rural Physician Practices

- 1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
- 2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
- 3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
- 4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
- 5. Our AMA will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities.

H-465.998 Addressing Payment & Delivery in Rural Hospitals

- 1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
 - c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
 - f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
- 2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.

3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-26)

Introduced by: Colorado, Arizona, Idaho, Utah, Washington, Wyoming

Subject: Physicians are not Providers

Referred to: Reference Committee B

- 1 Whereas, the term Provider has increasingly been used more broadly to include physicians; and
2
3 Whereas, the term Provider is too inclusive and confuses the Physician Patient relationship; and
4
5 Whereas, the term Provider has been utilized as an ambiguous term that inappropriately
6 conflates the credentials, training and experience of separate groups of healthcare
7 professionals; and
8
9 Whereas, the American Medical Association has increasing Concerns with scope of practice
10 and has joined lawsuits to preserve the physician role in medicine; and
11
12 Whereas, the AMA has existing policy H-405.968 stating that Our American Medical Association
13 supports requiring that health care entities, when using the term “provider” in contracts,
14 advertising and other communications, specify the type of provider being referred to by using
15 the provider’s recognized title which details education, training, license status and other
16 recognized qualifications; and supports this concept in state and federal health system reform;
17 and
18
19 Whereas, the action items associated with H-405-968 directed our AMA to
20 1. Consider the generic terms “health care providers” or “provider” as inadequate to describe the
21 extensive education and qualifications of physicians licensed to practice medicine in all its
22 branches.
23 2. Institute an editorial policy prohibiting the use of the term “provider” in lieu of “physician” or
24 other health professionals for all AMA publications not otherwise covered by the existing JAMA
25 Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA
26 and the JAMA Network Journals.
27 3. Forward to the editorial board of JAMA the recommendation that the term “physician” be use
28 in lieu of “provider” when referring to MD’s and DO’s; and
29
30 Whereas, the term provider continues to be the standard term for physicians in healthcare
31 entities; therefore be it
32
33 RESOLVED, that our American Medical Association take further advocacy actions to implement
34 Policy H-405.968 which prioritizes the use of the term “physician” when discussing those with an
35 MD or DO, and either “clinician” or “health care professional” as appropriate to describe those
36 with other varying credentials (Directive to Take Action); and be it further
37
38 RESOLVED, that our AMA Oppose the use of the term “provider” when used to include
39 physicians (New HOD Policy); and be it further

1 RESOLVED, that our AMA evaluate the issue of overbroad terminology using Provider for
2 Physician and others be evaluated for effect on patient education/awareness, transparency and
3 ethical responsibilities of physicians to patient safety and professionalism (Directive to Take
4 Action); and be it further

5

6 RESOLVED, that our AMA refer the issue of “Physicians are not Providers” to the board for
7 study and report back including possible consideration by the American Medical Association’s
8 Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)

9

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

Received: 4/16/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-26)

Introduced by: International Medical Graduates Section

Subject: Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States

Referred to: Reference Committee B

- 1 Whereas, International Medical Graduates (IMGs) constitute a critical component of the United
2 States physician workforce and play an essential role in providing care, particularly in
3 underserved and rural communities¹; and
4
- 5 Whereas, non-U.S. citizen IMGs frequently rely on non-immigrant visas, including J-1 and H-1B
6 programs, to participate in U.S. graduate medical education and subsequently serve in areas of
7 greatest physician and patient care need²; and
8
- 9 Whereas, recent federal actions, including presidential proclamations, have suspended or
10 limited visa issuance and entry for nationals of multiple countries, thereby affecting physicians
11 seeking to enter the United States for residency and fellowship training³; and
12
- 13 Whereas, these proclamations apply broadly to individuals outside the United States without
14 valid visas, including fully vetted physicians who have successfully matched into accredited U.S.
15 residency programs and satisfied rigorous screening, credentialing, and licensure
16 requirements²; and
17
- 18 Whereas, IMGs undergo extensive vetting through credential verification, standardized
19 examinations, background checks, and institutional review before entering U.S. training
20 programs⁴; and
21
- 22 Whereas, restricting the entry of qualified physicians may disrupt residency training pipelines
23 and adversely affect patient care, particularly in hospitals and communities dependent on
24 IMGs⁵; and
25
- 26 Whereas, the absence or delay of incoming resident physicians may compromise staffing at
27 teaching hospitals, reduce access to care, and exacerbate existing physician shortages⁶; and
28
- 29 Whereas, current proclamations allow for limited case-by-case national interest exceptions but
30 lack clear, consistent, and categorical exemptions for physicians entering the United States to
31 provide essential medical care³; and
32
- 33 Whereas, future presidential proclamations or similar federal actions may continue to impose
34 broad entry restrictions without explicit consideration of the essential role of physicians in
35 safeguarding public health³; therefore be it
36
- 37 RESOLVED, that our American Medical Association advocate for policies that ensure
38 appropriate consideration and avoidance of undue delays in visa processing, issuance, and
39 entry into the United States for fully vetted international medical graduates entering to

- 1 participate in accredited graduate medical education or provide patient care, while maintaining
2 necessary security and vetting procedures (Directive to Take Action); and be it further
3
4 RESOLVED, that our AMA monitor and report on the impact of such policies on International
5 Medical Graduate participation, physician workforce supply, patient access to care; and develop
6 recommendations for ongoing advocacy. (Directive to Take Action)

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

Received: 4/16/26

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RELEVANT AMA POLICY

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969

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

Res. 237, A-25

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
 - a. work with the ECFMG to minimize delays in the **visa** process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
 - b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
 - c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B **visa** denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Res. 844, I-03 Reaffirmation: A-09 Reaffirmation: I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 312, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-26)

Introduced by: Senior Physicians Section

Subject: Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges

Referred to: Reference Committee B

1 Whereas, the United States is experiencing a demographic rise in older persons that is creating
2 massive demand for long-term services and supports [LTSS] within the next 10-15 years [“peak
3 demand”]; and
4

5 Whereas, long-term care, including home- and community-based services (HCBS), are
6 essential to the health and quality of life of older adults and persons with disabilities; and
7

8 Whereas, the long-term care workforce has experienced chronic shortages that was markedly
9 exacerbated subsequent to the COVID-19 pandemic; and
10

11 Whereas, immigrants represent a substantial share of the direct care workforce in long term
12 care settings, and are disproportionately represented in rural and underserved communities;
13 and
14

15 Whereas, in communities where there is a higher proportion of immigrants, there is significant
16 decrease in mortality amongst older people^{1,2}; and
17

18 Whereas, recent administrative actions affecting immigration enforcement priorities including
19 loss of Temporary Protected Status will significantly adversely affect staffing levels, predictably
20 leading to lower quality of care and excess deaths; and
21

22 Whereas, the American Medical Association has long recognized the importance of long-term
23 care, workforce sustainability, and immigration policies that support the health care system
24 [H-280.951]; therefore be it
25

26 RESOLVED, that our American Medical Association oppose administrative or regulatory actions
27 that exacerbate staffing shortages or threaten access to long term care when such actions are
28 not accompanied by adequate workforce supply and training, immigration pathways, and
29 funding support (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA support immigration policies that protect, retain, and expand the
32 long-term care workforce, including timely work authorization, efficient visa processing, and
33 protections against abrupt workforce disruptions for immigrant health care workers. (New HOD
34 Policy)
35

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

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RELEVANT AMA POLICY**H-440.793 Mass Deportation as a Public Health Issue**

1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts.

[Res. 931, I-24]

H-65.932 Reducing the Harmful Impacts of Immigration Status on Health

1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
2. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
3. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.
4. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates.

[Res. 004, A-25]

H-280.951 Quality of Care and Staffing in Nursing Homes

Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.

[Sub. Res. 109, A-06; Modified: CMS Rep. 01, A-16]

H-280.945 Financing of Long-Term Services and Supports

1. Our American Medical Association supports policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans.
2. Our AMA supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees.
3. Our AMA supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI.
4. Our AMA supports innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities.
5. Our AMA supports permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy.
6. Our AMA supports Medicare Advantage plans offering LTSS in their benefit packages.
7. Our AMA supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit.
8. Our AMA supports a back-end public catastrophic long-term care insurance program.

9. Our AMA supports incentivizing states to expand the availability of and access to home and community-based services; and
10. Our AMA supports better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.
[CMS Rep.05, A-18; Reaffirmed: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 4, I-21; Reaffirmed A-23; Modified: Res. 815, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-26)

Introduced by: Illinois

Subject: Banning Flavored Cannabis E-Cigarettes

Referred to: Reference Committee B

1 Whereas, vaping e-cigarettes has been a popular form of nicotine and cannabis delivery for
2 approximately twenty years; and
3
4 Whereas, on April 2, 2025, the Supreme Court unanimously ruled that the U.S. Food and Drug
5 Administration (FDA) lawfully denied marketing authorization for certain flavored e-liquids used
6 in electronic nicotine delivery systems (ENDS), otherwise known as e-cigarettes (ECIG) or
7 “vapes;” and
8
9 Whereas, a recent analysis revealed five clusters of reasons for flavored ECIG use including
10 Increased Satisfaction/Enjoyment, Better Feel/Taste than Cigarettes, Variety/Customization,
11 Food Craving Suppression, and Social Impacts; and
12
13 Whereas, flavors may make ECIG use more satisfying and may increase abuse potential,
14 product appeal, and/or reinforcing effects; and
15
16 Whereas, cannabis can have a strong, earthy, or even bitter taste, which some users find
17 unpalatable; and
18
19 Whereas, flavored cartridges offer a way to mask the unpleasant taste of cannabis, making the
20 vaping experience more pleasant to the user; and
21
22 Whereas, flavors in both nicotine and cannabis vape products increased adolescents’
23 willingness to try them; and
24
25 Whereas, cannabis vape products can readily be brought into schools where their use can be
26 very hard to detect; and
27
28 Whereas, marijuana vapes use increased by 10.1 percent for 12th grade students, between
29 2017 and 2023, with just under 20 percent of 12th grade students reported vaping marijuana in
30 2023; and
31
32 Whereas, use of marijuana increased by 5 and 3.5 percent for 10th grade and 8th grade
33 students, respectively, between 2017 and 2023; and
34
35 Whereas, approximately one-third (34.5%) of U.S. 12th-grade students who consumed
36 cannabis in 2018 did so by vaping, compared to 19.8 % in 2016; and
37
38 Whereas, median maximum concentrations (Cmax) for the cannabis metabolite THCCOOH
39 were qualitatively higher after administration of vaporized cannabis compared to equal doses of
40 smoked cannabis; and

1 Whereas, National Poison Data System (NPDS) statistics from 2016 through 2023 noted of the
2 4122 total e-cigarette calls, 1816 (44.1%) were treated at health care facilities (HCF); by
3 comparison, there were 37,971 total tobacco e-cigarette calls of which 7401 (19.5%) were
4 treated at HCF (Chi square with Yates correction two-tailed P value is < 0.0001); and

5
6 Whereas, there was an adolescent preponderance of both the flavored (57 adolescents versus
7 27 adults) and the unflavored calls (44 adolescents versus 33 adult calls); and

8
9 Whereas, in the same analysis, toddlers (39.8%) and adolescents (33.4%) trended to be much
10 more prevalent than adults (17.9%) throughout all categories of single exposure cannabis e-
11 cigarette encounters with national poison centers; and

12
13 Whereas, a recent meta-analysis which included youth and adult studies reported that among
14 individuals who used cannabis, 22% met criteria for Cannabis Use Disorder (CUD) (95% CI
15 18%–26%. CUD was most prevalent in young adults, there being among the cohort of cannabis-
16 using 21-year-old emerging adults a very high risk of CUD (41.1%, 95% CI 38.4%–43.8%); and

17
18 Whereas, prospective evidence suggests higher potency cannabis which is now exceedingly
19 common (THC content averaging $\geq 12.3\%$), increases risk for onset of first cannabis use
20 disorder symptom by almost five-fold within the first year of use; and

21
22 Whereas, cannabis is a drug with high potential for abuse, particularly in young adults, with use
23 potentially leading to severe psychological or physical dependence and is not a drug with a
24 moderate to low potential for physical and psychological dependence; therefore be it

25
26 RESOLVED, that our American Medical Association advocate and support a complete ban on
27 the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges
28 throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet
29 selling hemp products and public health entities (Directive to Take Action); and be it further

30
31 RESOLVED, that our AMA pursue legislative changes concerning a comprehensive ban on the
32 production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the
33 United States. (Directive to Take Action)

34
Fiscal Note: Modest – between \$5,000 - \$10,000

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our American Medical Association believes that cannabis is a dangerous drug and as such is a serious public health concern.

Our AMA believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older).

Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant people, and people who are breastfeeding.

Our AMA believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth.

Our AMA believes laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness.

Our AMA encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency

department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder. Our AMA supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.

Our AMA encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety.

Our AMA encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.

Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.

Our AMA supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities.

Our AMA will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-26)

Introduced by: Illinois Delegation

Subject: Banning Synthesized, Purified or Derivative Products from Kratom

Referred to: Reference Committee B

1 Whereas, kratom (*Mitragyna speciosa*) is a plant indigenous to Southeast Asia, typically
2 consumed by tea or powder, with physiologic effects like opioids, as well as stimulants. There is
3 an increasing prevalence of kratom use, raising concern for possible dependence, addiction,
4 and toxicity; and

5
6 Whereas, an estimated 1.7 million Americans aged 12 and older used kratom in 2021,
7 according to the Substance Abuse and Mental Health Services Administration; and

8
9 Whereas, a recent cross-sectional survey utilizing a non-probabilistic nationally representative
10 sampling with a total of 11,545 respondents of which 1,049 reported current kratom use,
11 indicating a 9.1% prevalence. The most common kratom products used in the past 30 days
12 were pills, gummies and powder formulations. A higher incidence of adverse effects was
13 reported as the amount of kratom per dose increased with gummies/capsules/tablets/pills; and

14
15 Whereas, in a recent study of secret shopper visits were conducted at 100 San Antonio and
16 Austin, Texas smoke shops. kratom (94%) was routinely stocked by smoke shops. When
17 specifically asked about adverse effects, 24% of smoke shop employees did not disclose any
18 risks about kratom; most others provided minimal information; and

19
20 Whereas, kratom has only four known pharmacologically active compounds. Of these active
21 compounds, mitragynine is the most prevalent, but 7-OH-mitragynine is more pharmacologically
22 active; and

23
24 Whereas, mitragynine toxicity can cause a range of adverse effects, including organ damage,
25 seizures, and respiratory depression, particularly at high doses. The risk is significantly
26 heightened when mitragynine, a major psychoactive compound in kratom, is taken in
27 combination with other drugs; and

28
29 Whereas, a study by the National Poison Data system (NPDS) in 2019 found that the most
30 common presenting symptoms after kratom ingestion included agitation, tachycardia,
31 drowsiness, and confusion; and

32
33 Whereas, mitragynine poses a risk to recreational users and those using it as a natural remedy
34 or nutritional supplement due to lack of medical supervision or oversight/regulation; and

35
36 Whereas, although the alkaloid content naturally ranges from 2 to 6% in native leaf material, it
37 can be up to 60% in concentrated extracts; and

38
39 Whereas, 7-hydroxymitragynine (7-OH) is a naturally occurring alkaloid in the kratom plant, but
40 only a minor constituent that comprises less than 2% of the total alkaloid content in natural

1 kratom leaves. However, 7-OH demonstrates substantially greater mu-opioid receptor potency
2 (a compound 5–20 times more potent than mitragynine and an estimated 13 times more potent
3 than morphine) than kratom’s primary alkaloid constituent mitragynine; and
4

5 Whereas, in the current marketplace in the U.S., 7-OH is increasingly being marketed over the
6 counter and online, in concentrated forms or sufficient doses to cause harms to those
7 individuals engaging, knowingly or unknowingly, in use of 7-OH; and
8

9 Whereas, the availability of 7-OH products is a major concern to the FDA, as consumers can
10 easily purchase products with concentrated levels of 7-OH online and in gas stations, corner
11 stores and vape shops. The FDA is particularly concerned with the growing market for 7-OH
12 products that may be especially appealing to children and teenagers, such as fruit-flavored
13 gummies and ice cream cones. These products may not be clearly or accurately labeled as to
14 their 7-OH content and are sometimes disguised or marketed as kratom; and
15

16 Whereas, there are no FDA-approved products containing 7-OH; and
17

18 Whereas, in June 2025, the FDA issued warning letters to seven companies for illegally
19 distributing products containing 7-OH, including tablets, gummies, drink mixes and shots; and
20

21 Whereas, in 2021, the NPDS included 1,524 kratom case mentions. Of those, 948 were single
22 exposure reports, of which 67 were associated with major medical outcomes and four
23 associated deaths; and
24

25 Whereas, according to recent NPDS data (reporting period: 2/1/2025-4/30/2025); there were a
26 total of 53 exposure cases involving 7-OH during this period, the majority of which involved
27 abuse related reasons for use (i.e., “intentional abuse”). Most single-substance 7-OH exposure
28 cases resulted in minor or moderate clinical outcomes, with several documented having major
29 clinical outcomes; and
30

31 Whereas, forty cases of death by mitragynine were identified from the Medical Examiners in
32 Florida over a five-year period while the L.A. County medical examiner has reported six
33 overdose deaths in LA County residents between the ages of 18 to 40 years old in the first ten
34 months of 2025 as involving 7-OH; and
35

36 Whereas, analysis of kratom and its analogues (particularly mitragynine and 7-OH-mitragynine)
37 in urine or blood are not available at any hospital based clinical chemistry laboratory; and
38

39 Whereas, kratom products do not meet basic quality control standards for purity analysis,
40 product constituent levels, standard labeling and accurate warnings to ensure public education
41 and safety; and
42

43 Whereas, among the southeast Asian countries, Malaysia, Myanmar, and Singapore consider
44 the kratom plant, mitragynine, and 7-hydroxymitragynine (7-OH) as prohibited from
45 consumption, possession, and trade; and
46

47 Whereas, medicinal chemistry efforts have led to synthetic 7-OH derivatives such as MGM-15,
48 where stereospecific saturation of the imine N (1)–C (2) double bond increases opioid receptor
49 affinity and activity. Despite its higher in vitro opioid potency, MGM-15 is currently sold in the US
50 for human consumption as a “research chemical” in tablet form, even though there is an
51 absence of this being studied in humans and obviously no FDA approval. MGM-15 shows

1 greater opioid receptor binding affinities than 7-OH, indicating the potential for higher opioid
2 effects and risks; and

3
4 Whereas, these unregulated products are packaged in a way to market themselves to minors;
5 these products have no minimum purchase age, nor do they require an ID check for age
6 verification. In addition, many of these retailers have shops that are close to school grounds,
7 playgrounds, and other public places that are widely accessible to minors; therefore be it

8
9 RESOLVED, that our American Medical Association pursue legislation banning synthesized,
10 purified or derivative products from kratom for marketing, distribution, promotion and sale
11 including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and
12 MGM-15 market. (Directive to Take Action)

13
Fiscal Note: Modest – between \$5,000 - \$10,000

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RELEVANT AMA POLICY

Regulate Kratom and Ban Over-the-Counter Sales H-95.903

1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials, and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.

2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.

Res. 515, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-26)

Introduced by: International College of Surgeons

Subject: Physician Unity in Advocacy Regarding Physician Reimbursement

Referred to: Reference Committee B

1 Whereas, the American Medical Association (AMA) House of Delegates serves as the principal
2 policy-making body representing physicians across specialties and practice settings in the
3 United States; and
4

5 Whereas, physician payment systems under the Medicare Physician Fee Schedule operate
6 under statutory budget neutrality requirements, which often result in reductions in
7 reimbursement to some physician services when increases occur elsewhere; and
8

9 Whereas, AMA policy D-400.982, "AMA Efforts on Physician Payment Reform," recognizes that
10 instability and reductions in physician reimbursement threaten the sustainability of medical
11 practice and patient access to care; and; AMA policy H-400.972, "Physician Payment
12 Reform," supports stable and predictable payment updates to protect physician practices and
13 maintain patient access to physician services; and
14

15 Whereas, AMA policy H-390.849, "Principles for Physician Payment Reform," affirms that
16 physician payment systems should ensure adequate reimbursement for physician services and
17 promote access to high-quality care; and; AMA policy H-450.947, "Pay-for-Performance
18 Principles and Guidelines," emphasizes that physician payment reforms should avoid
19 unintended consequences that undermine the delivery of patient care; and Advocacy by one
20 physician specialty or physician organization for reductions in reimbursement directed toward
21 another physician specialty risks undermining physician unity and may contribute to policies that
22 weaken the physician workforce and reduce patient access to care; therefore be it
23

24 RESOLVED, that our American Medical Association reaffirm that physician payment reform
25 should prioritize the sustainability of the entire physician workforce and the protection of patient
26 access to care (New Hod Policy); and be it further
27

28 RESOLVED, that our AMA adopt policy stating that physicians and physician organizations
29 should refrain from advocating for reductions in reimbursement specifically targeted at other
30 physician specialties or physician groups (Directive to Take Action); and be it further
31

32 RESOLVED, that our AMA encourage physician organizations to pursue payment reform
33 through approaches that improve overall fairness, adequacy, and stability of physician
34 reimbursement rather than redistribution among physician specialties (Directive to Take Action);
35 and be it further
36

37 RESOLVED, that our AMA affirm that physicians should advocate collectively against
38 reimbursement cuts affecting any group of physicians and support efforts to protect the financial
39 sustainability of all physician practices in order to preserve patient access to care. (New HOD
40 Policy)

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

Received: 4/19/26

RELEVANT AMA POLICY

D-400.982 AMA Efforts on Medicare Payment Reform

Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases. BOT Rep. 12, A-24Reaffirmed: Res. 220, I-24

H-400.972 Physician Payment Reform

It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS Sub. Res. 109, A-92Reaffirmed: I-92Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95Reaffirmation A-99 and Reaffirmed: Res. 127, A-99Reaffirmation A-02Reaffirmation A-06Reaffirmation I-07Reaffirmed: BOT Rep. 14, A-08Reaffirmation A-09Reaffirmed: CMS Rep. 01, A-19Reaffirmed: Res. 212, I-21Reaffirmed: Res. 802, I-24

H-390.849 Physician Payment Reform

Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles: Promote improved patient access to high-quality, cost-effective care. Be designed with input from the physician community. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions. Not require budget neutrality within Medicare Part B. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice. CMS Rep. 6, A-09Reaffirmation A-10Appended: Res. 829, I-10Appended: CMS Rep. 1, A-11Appended: CMS Rep. 4, A-11Reaffirmed in lieu of Res. 119, A-12Reaffirmed in lieu of Res. 122, A-12Modified: CMS Rep. 6, A-13Reaffirmation I-15Reaffirmation: A-16Reaffirmed in lieu of: Res. 712, A-17Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17Reaffirmation: A-19Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Reaffirmed: Res. 212, I-21Reaffirmed: Res. 240, A-22Reaffirmation: A-22Modified: CMS Rep. 04, A-23Reaffirmed: Res. 214, A-23Reaffirmation: A-23Reaffirmed in lieu of: Res. 225, A-25Reaffirmed: Res. 226, A-25

H-450.947 Pay-for-Performance Principles and Guidelines

Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." BOT Rep. 5, A-05Reaffirmation A-06Reaffirmed: Res. 210, A-06Reaffirmed in lieu of Res. 215, A-06Reaffirmed in lieu of Res. 226, A-06Reaffirmation I-06Reaffirmation A-07Reaffirmation A-09Reaffirmed: BOT Rep. 18, A-09Reaffirmed in lieu of Res. 808, I-10Modified: BOT Rep. 8, I-11Reaffirmed: Sub. Res. 226, I-13Appended: BOT Rep. 1, I-14Reaffirmed in lieu of Res. 203, I-15Reaffirmed in lieu of Res. 216, I-15Reaffirmation I-15Reaffirmed: BOT Rep. 20, A-16Reaffirmed in lieu of: Res. 712, A-17Reaffirmation: A-18Reaffirmation: A-22Reaffirmed: CMS Rep. 07, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Establishing Healthcare Monitoring and Accountability in Immigration
Detention Facilities

Referred to: Reference Committee B

1 Whereas, United States Immigration and Customs Enforcement's (ICE) Enforcement and
2 Removal Operations (ERO) officers are given the authority to enforce immigration laws within
3 the interior through the arrest, detention, and removal of undocumented individuals with the
4 stated purpose of protecting national security and public safety;¹ and
5

6 Whereas, immigration detention is civil custody, not criminal incarceration, yet ICE and contract
7 facilities use criminal detention infrastructures, despite 41,589 out of 58,766, (70.8%) of
8 detainees at immigration detention centers holding no criminal convictions, creating gray areas
9 that allow facilities to bypass health protections;^{2,3} and
10

11 Whereas, the number of people detained by ICE rose from 39,587 on January 19, 2025, to
12 58,766 on September 7, 2025, nationwide reflecting a rapid escalation in immigration detention
13 practices;^{4,5} and
14

15 Whereas, immigration detention centers comprise a variety of facilities in order to detain
16 noncitizens of the United States, including county jails, state and federal prisons, private
17 detention centers, hotels, and even federal office buildings but most individuals detained by ICE
18 are imprisoned in facilities that are either owned or run by private or for-profit prison
19 companies;⁶⁻⁸ and
20

21 Whereas, the National Standards on Transport, Escort, Detention, and Search (TEDS) has
22 created guidelines to ensure individuals in immigration detention centers receive basic
23 necessities, such as hygiene, food and water, and medical care; however, individuals have
24 experienced poor conditions such as cold temperatures, lack of medical care, and inadequate
25 food with minimal religious dietary accommodations;⁶ and
26

27 Whereas, 42.5% of individuals in immigration detention centers have at least one chronic
28 medical condition, underscoring the elevated need for continuous care, particularly given the
29 average detention stay of 421 days; yet, many detainees report significant disruptions in care,
30 including delays in treatment, medication interruptions, denial of language interpretation
31 services, and lack of follow-up for chronic illnesses;⁹⁻¹⁰ and
32

33 Whereas, between 2018 and 2019, nearly 900 detainees across 57 ICE detention facilities in 19
34 states were infected during a mumps outbreak, illustrating inadequate infection control
35 measures;¹¹ and
36

37 Whereas, independent reviews of 52 deaths in ICE custody between 2017 and 2021 found that
38 95% were preventable with adequate medical care, underscoring systemic failures in clinical
39 oversight, chronic disease management, and emergency response protocols;¹² and

1 Whereas, during investigations of deaths during ICE detention, ICE allowed facilities to
2 destroy evidence, omit inculpatory facts, fail to interview key witnesses, and lack a standardized
3 criteria for autopsies;¹² and
4

5 Whereas, there has been a documented elevenfold increase in suicide rates and preventable
6 deaths in ICE custody, with the death rate in immigration facilities within the first six months of
7 2025 being the highest rate of any publicly available year, attributed to systemic failures in
8 mental health care, solitary confinement practices, and inadequate medical evaluation
9 protocols;^{9,13-15} and
10

11 Whereas, oversight mechanisms remain inadequate as the Office of Detention Oversight (ODO)
12 only conducts 25% of inspections, with other inspections done privately or as self-assessments,
13 and private entities identify less than half of the deficiencies identified by (ODO), are criticized
14 as superficial and ineffective, and ICE personnel report that inspectors frequently conduct only
15 perfunctory reviews of standards;^{17, 19-21} and
16

17 Whereas, comprehensive inspections conducted by ODO occur only once every three years on
18 average, allowing documented violations, such as inadequate medical care, suicide risk,
19 mismanagement, and unreported abuse, to persist without timely corrective action;^{20,22-24} and
20

21 Whereas, ICE facilities continue to rely on pre-announced inspections, often only every three
22 years, and are frequently granted waivers that allow facilities to bypass critical health and safety
23 standards outlined by the National Detention Standards, ranging from waivers allowing strip
24 searches to those exempting facilities from complying with fire prevention standards;²¹⁻²⁴ and
25

26 Whereas, when faced with knowledge of over 14,000 deficiencies in adherence to procedures at
27 106 contract facilities, including those that put the health and safety of detainees at risk, ICE
28 only imposed financial penalties on two instances and issued waivers at other facilities;¹⁷ and
29

30 Whereas, ICE has no formal policies or procedures in place to guide the waiver process and
31 has allowed Enforcement and Removal Operations (ERO) officers to grant waivers without clear
32 authority to do so, causing only 3 waivers in a sample of 65 to have an expiration date, meaning
33 many facilities may permanently avoid compliance;^{17,22} and
34

35 Whereas, in light of the persistent use of detention facilities, it remains an ethical and public
36 health imperative to ensure that detained individuals receive humane, timely, and appropriate
37 medical and mental health care, to the fullest extent possible, as an interim measure of health
38 accountability;²³⁻²⁵ and
39

40 Whereas, evidence from carceral health systems shows that independent, transparent, and
41 frequent reporting of health metrics, particularly when conducted by external monitors and
42 publicly disclosed, can improve care quality, and that carefully structured financial incentives
43 tied to health outcomes may further encourage high standards of care in immigration detention
44 facilities;²⁶⁻²⁸ therefore be it
45

46 RESOLVED, that our American Medical Association support independent, transparent,
47 unannounced inspections of all ICE detention facilities, with anti-retaliation protections for
48 detainees and health staff who participate (New HOD Policy); and be it further
49

50 RESOLVED, that our AMA supports efforts to reform ICE's waiver system by requiring that all
51 waivers include clear expiration dates, transparent public reporting, and standardized criteria
52 that limit their use to cases of demonstrated necessity. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 04/20/2026

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RELEVANT AMA POLICY

D-350.983 Improving Medical Care in Immigrant Detention Centers

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

H-350.957 Addressing immigrant health disparities

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health, and supports legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. 3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient-centered, language and culturally appropriate way upon presentation for asylum, regardless of country of origin. 4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers. 5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers. 6. Our AMA urges physicians to provide medically appropriate care for asylum seekers. 7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services. 8. Our AMA encourages the provision of resources to assist people seeking asylum, including social and legal services. [Res. 804, I-09Appended: Res. 409, A-Reaffirmation: A-19Appended: Res. 423, A-19 Reaffirmation: I-19Modified: BOT Rep. 08, I-24]

H-65.934 Opposition to the Deceptive Relocation of Migrants and Asylum Seekers

1. Our American Medical Association opposes the relocation of migrants and asylum-seekers by state or federal authorities without timely and appropriate resources to meet travelers' needs, especially when deceptive or coercive practices are used.
2. Our AMA supports state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations.

[Res. 006, I-24]

H-65.938 Guiding principles for the health care of migrants

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing

mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.

6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
 - a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
 - b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
 - c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
 - d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
 - e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

[Res. 016, A-24]

H-406.987 Medical Information and its uses

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients, and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive

use of health care data. **Data Availability** - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete. **Access to Timely Data** - While some datasets will require more frequent updates than others, our AMA encourages the use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter. **Accurate Data** - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used. **Use of Quality Data** - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement. **Increasing Data Utility** - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility, and reduce barriers that currently limit access to and use of the health care data. **Standardization** - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats. **Mitigating Administrative Burden** - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary. **Data Attribution** - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s), as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused on the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15 Reaffirmation: I-18 Reaffirmed: CSAPH Rep. 2, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-26)

Introduced by: LGBTQ+ Section, Medical Student Section, American College of Physicians

Subject: Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care

Referred to: Reference Committee B

- 1 Whereas, AMA Policy G-605.009 established the Task Force to Preserve the Patient-Physician
2 Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to guide
3 organized medicine's response to restrictions on evidence-based care and to create
4 implementation-focused advocacy and practice resources; and
5
6 Whereas, Policy G-605.009 explicitly anticipates and prepares for bans on other appropriate
7 health care, including gender-affirming care, and calls for identification of information and
8 resource gaps and the creation of implementation blueprints to mitigate harm; and
9
10 Whereas, the Task Force has demonstrated effectiveness in developing implementation tools,
11 including landscape analyses, litigation monitoring, partnership with legal defense networks,
12 physician education, and creation of the Reproductive Health Resource Navigator as a
13 centralized digital resource hub¹; and
14
15 Whereas, restrictions on gender-affirming care have proliferated in multiple jurisdictions and
16 across numerous levels of government and regulatory agencies, creating significant legal
17 uncertainty, regulatory confusion, reimbursement barriers, institutional policy variability, and
18 potential civil, criminal, and professional liability risk for physicians²⁻⁴; and
19
20 Whereas, medical students, residents, and fellows in states with restrictions face diminished
21 training opportunities in gender-affirming care, threatening workforce preparedness and future
22 access to appropriate and evidence-based care, with resultant decreased physician workforce
23 in such restricted states⁴⁻⁶; and
24
25 Whereas, physicians require centralized, up-to-date, practical guidance addressing evolving
26 statutory restrictions, shield laws, privacy protections, telehealth considerations, interstate
27 licensure, documentation standards, payer policies, institutional risk mitigation, and medical
28 liability concerns; and
29
30 Whereas, gender-affirming care is multi-specialty care, positioning the AMA as an effective
31 convener of representatives across specialties to facilitate collaborative efforts⁷; and
32
33 Whereas, organized medicine has an ethical obligation to defend the patient-physician
34 relationship and ensure that physicians can provide evidence-based, patient-centered care
35 without undue interference; therefore be it
36
37 RESOLVED, that our American Medical Association extend and expand the work of the Task
38 Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care

1 Is Banned or Restricted to include a formalized and sustained focus on legislative and
2 regulatory actions to protect access to and education in gender-affirming care (Directive to Take
3 Action); and be it further

4
5 RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a
6 comprehensive, centralized digital resource hub—modeled on the Reproductive Health
7 Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026
8 Interim Meeting, including but not limited to:

- 9
10 1. State-specific legal summaries and regulatory guidance;
11 2. Shield law analyses and cross-state practice considerations;
12 3. Privacy and HIPAA compliance best practices;
13 4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
14 5. Documentation and informed consent templates consistent with evolving legal
15 standards;
16 6. Coding, billing, and reimbursement guidance;
17 7. Institutional policy templates and sample protocols;
18 8. Educational and training resources for undergraduate and graduate medical education;
19 9. Telehealth and interstate licensure guidance; and
20 10. Information regarding legal assistance and physician defense resources (Directive to
21 Take Action); and be it further

22
23 RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to
24 oppose criminalization and punitive actions against physicians providing evidence-based
25 gender-affirming care and to support legal protections safeguarding the patient-physician
26 relationship, with guidance by the Task Force (Directive to Take Action); and be it further

27
28 RESOLVED, that our AMA identify gaps in information and resources and develop a
29 comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on
30 safe, evidence-based, and medically appropriate health care (Directive to Take Action); and be
31 it further

32
33 RESOLVED, that our AMA report annually to the House of Delegates regarding progress on
34 these deliverables, including metrics on resource utilization, physician engagement, and
35 identified advocacy outcomes. (Directive to Take Action)

36
Fiscal Note: Major – To Be Determined

Received: 4/20/26

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RELEVANT AMA POLICY

G-605.009 Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
 - a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
 - b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
 - c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
 - d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
 - e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
 - f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
 - g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
 - h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care. [Res. 621, A-22 Appended: Res. 816, I-23 Appended: Res. 207, I-24]

D-605.982 Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance

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

[Res. 207, I-24]

D-5.998 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era

1. Our American Medical Association Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.
2. Our AMA will work to facilitate support, including legal support through the AMA Litigation Center, as may be appropriate, to physicians that are targeted for practicing in accordance with accepted standards of medical care and medical ethics in the face of legal constraint or any other disciplinary action.
3. Our AMA will advocate for affirmative protections for "conscientious provision" of care in accordance with accepted standards of medical care and medical ethics in hostile environments on par with protection of "conscientious objection."

[Res. 008, I-22 Reaffirmation: A-23]

H-275.937 Patient/Physician Relationship and Medical Licensing Boards

Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations:

1. Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are:
 - a. open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in their care;
 - b. commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests;
 - c. provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less; and
 - d. avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.
 2. The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.
 3. Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.
 4. The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.
 5. A (name of state) physician has both medical-legal and ethical obligations to their patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients.
- [BOT Rep. 30, I-98 Reaffirmed: CME Rep. 2, A-08 Modified: CME Rep. 01, A-18 Modified: Speakers Rep. 02, I-24]

D-275.942 Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care

1. Our American Medical Association advocates that no physician be disqualified from medical licensure or subject to unnecessary delay in the licensure process solely due to having provided abortion care or gender-affirming care in accordance with then-current standards of medical practice and/or while such care was legal in their jurisdiction.

2. Our AMA supports policies, legislation, and state medical society initiatives that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care.

3. Our AMA will work with relevant interested parties, including state medical boards and specialty societies, to support the development of guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming. [Res. 231, I-25]

H-65.964 Access to Basic Human Services for Transgender Individuals

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity. [Res. 010, A-17]

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.

[CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24 Appended: Res. 413, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-26)

Introduced by: Texas

Subject: Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan

Referred to: Reference Committee B

1 Whereas, the \$35 cap on insulin copays only applies to specific brand or version on a plan's
2 formulary; and
3

4 Whereas, although plan formularies are available online in real-time, accurate information can
5 be delayed or unavailable, especially during a plan change; and
6

7 Whereas, timely access to insulin is required to prevent acute decompensation of diabetes;
8 therefore be it
9

10 RESOLVED, that our American Medical Association adopt as policy and advocate that
11 beneficiaries of ERISA-governed health plans be allowed a 30-day transition fill of insulin at the
12 beginning of each plan year to allow time for the formulary preference to be determined by the
13 patient and prescriber. (Directive to Take Action)
14

Fiscal Note: Minimal – less than \$5,000

Received: 4/20/26

RELEVANT AMA POLICY

H-100.964 Drug Issues in Health System Reform

1. Our American Medical Association consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
2. Our AMA supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
3. Our AMA reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
4. Our AMA supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
5. Our aMA supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
6. Our AMA encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
 - a. Our AMA encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of

medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.

7. Our AMA reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.

H-110.984 Insulin Affordability

1. Our American Medical Association will encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate.
2. Our AMA supports initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
3. Our AMA supports state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-26)

Introduced by: Texas

Subject: Prohibiting the Independent Practice of Medicine by Artificial Intelligence

Referred to: Reference Committee B

1 Whereas, artificial intelligence (AI) is a powerful tool in augmenting the delivery of high quality
2 health care and in expanding access to care in rural and underserved areas; and
3

4 Whereas, AI can enhance diagnostic capabilities and help with remote patient monitoring and
5 automation of administrative tasks; and
6

7 Whereas, AI can provide accessible health education to patients through online platforms and
8 apps; and
9

10 Whereas, AI can assist primary care physicians by collecting data regarding rural care for
11 analysis, and evaluating large datasets to enhance care approaching levels similar to urban
12 centers; and
13

14 Whereas, the “Healthy Technology Act of 2025” (H.R. 238) has been introduced in the U.S.
15 House of Representatives to explore the possibility of allowing FDA approved AI to prescribe
16 drugs; and
17

18 Whereas, H.R. 238 asks that AI be authorized by state law; and
19

20 Whereas, the One Big Beautiful Bill House version approved a 10-year moratorium on state AI
21 legislation that was not passed by the Senate; therefore be it
22

23 RESOLVED, that our American Medical Association advocate for legislation and regulation
24 prohibiting the use of artificial intelligence (AI) as an independent diagnostic or prescriptive tool
25 or as a care management substitute for a physician. (Directive to Take Action)
26

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

Received: 4/20/26

RELEVANT AMA POLICY

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954

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

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
 - a. clinical validation.
 - b. alignment with clinical decision-making that is familiar to physicians.
 - c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
 - a. be informed by real world workflow and human-centered design principles.
 - b. enable physicians to prepare for and transition to new care delivery models.
 - c. support effective communication and engagement between patients, physicians, and the health care team.
 - d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
 - e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
 - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
 - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
 - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
 - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
 - a. Identify areas of medical practice where AI systems would advance the quadruple aim.
 - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
 - c. Outline new professional roles and capacities required to aid and guide health care AI systems.
 - d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-26)

Introduced by: American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Medicare Administrative Contractor Policy Modification

Referred to: Reference Committee B

1 Whereas, recent Local Coverage Determination (LCD) proposals have called for drastic
2 changes in Medicare coverage for botulinum toxin injections for spasticity and for peripheral
3 nerve blocks; and
4

5 Whereas, the comment period for new or revised LCDs is only 45 days, which does not provide
6 sufficient time to develop a robust response given the scope and breadth of most LCDs and
7 Medicare Administrative Contractors (MACs) requests for detailed references and objective data
8 to be submitted with any comments; and
9

10 Whereas, these LCDs are lengthy with tremendous breadth and include a variety of procedures,
11 and a comprehensive literature review of potential impacts takes more time to assemble; and
12

13 Whereas, more time would allow specialty societies to engage their subject matter experts and
14 work collaboratively; and
15

16 Whereas, the Billing and Coding Local Coverage Article (LCA) that accompanied a recent
17 botulinum toxin LCD took effect despite concerns raised by specialty societies and inadvertently
18 eliminated coverage for diagnostic codes including quadriplegia, paraplegia, and monoplegia
19 because they did not contain the word "spastic" in the code's descriptor, and there was not a
20 separate ICD10 code for spasticity (until a formal reconsideration resulted in a revised policy);
21 and
22

23 Whereas, the MAC's initial decision regarding botulinum toxin injections caused delays in care
24 for patients with spasticity due to spinal cord injury which adversely affected their medical care
25 and function; and
26

27 Whereas, the MAC's proposed LCD on peripheral nerve blocks will adversely affect patients
28 with chronic pain who get relief from the injections rather than chronic opioids; therefore be it
29

30 RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder
31 Engagement in Medicare Administrative Contractor Policy, by addition to read:
32

33 1. Our American Medical Association opposes Medicare Administrative Contractors (MACs)
34 using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or
35 access without providing data and evidentiary review or without issuing associated Local
36 Coverage Determinations (LCDs) and following required stakeholder processes.

37 2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS)
38 to improve the instructions to MACs regarding development of local coverage policies in such a
39 manner as to prevent LCAs that could have the effect of restricting coverage or access from

1 being adopted without the MAC providing public data, decision criteria, and evidentiary review
2 and allowing comment, or without an associated LCD and the required LCD stakeholder review
3 and input process.

4 3. Our AMA will work with specialty and state medical societies and other interested
5 stakeholders to identify LCAs that potentially restrict coverage or access and that were issued
6 without the MACs providing opportunities for stakeholder input, public data, decision criteria,
7 and evidentiary review and advocate that CMS require MACs to revise the policies by taking
8 any such proposed changes through an appropriate stakeholder engagement, public data, and
9 evidentiary review.

10 4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment
11 period for new or revised LCDs.

12 5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for
13 new or revised LCDs that involve patient access to an intervention that may preserve life and/or
14 function.

15 6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the
16 removal of diagnostic codes from the list of diagnoses included as medically necessary for any
17 procedure in a proposed new or revised LCA (Modify Current HOD Policy); and be it further
18

19 RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National
20 Coverage Decisions (Reaffirm HOD Policy); and be it further

21
22 RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage
23 Determination Process. (Reaffirm HOD Policy)

24
Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 4/20/26

RELEVANT AMA POLICY

D-330.918 Appropriateness of National Coverage Decisions

1. Our American Medical Association will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care.

2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice.

D-330.897 Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.

2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.

3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and

advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.

D-330.908 Improving the Local Coverage Determination Process

1. Our AMA will advocate through legislative and/or regulatory efforts as follows:

A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD;

B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to:

A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Ending Private Equity Dividend Recapitalization in Healthcare

Referred to: Reference Committee B

1 Whereas, AMA Policy D-160.904, which states: “Our American Medical Association will propose
2 appropriate guidelines for the use of private equity (PE) in health care, ensuring that physician
3 autonomy and operational authority in clinical care are preserved and protected”; and
4

5 Whereas, “Private equity” is an asset class that invests capital directly into private companies
6 not listed on public stock exchanges. PE firms typically raise, buy, restructure, and extract profit
7 from acquired businesses, aiming to sell them for a profit after a limited number of years, such
8 that profit generation becomes a higher priority than excellent service delivery; and
9

10 Whereas, increasing numbers of physician practices, hospitals, and other enterprises that
11 provide health care are being purchased by PE corporations, such that within the past decade,
12 PE corporations have invested more than \$1 trillion into health care acquisitions, including at
13 least 17% of Urgent Care Centers and between 25-40% of Emergency Departments¹; and
14

15 Whereas, a key component of the business model which PE firms utilize when they extract
16 profits from health care enterprises that they acquire involves the practice of “Dividend
17 Recapitalization”, a financial strategy by which a PE company purposefully takes on new debt to
18 enable payment of an immediate special dividend to its shareholders; and

19 Whereas, for Dividend Recapitalization to enable this special dividend, a PE corporation
20 borrows funds, usually through a new loan issued from syndicated leveraged loan markets, or
21 by the issuing of corporate bonds. Whether raised by a new loan or a bond issue, this source of
22 funds is then used to pay the large, one-time dividend to shareholders noted above. This
23 process simultaneously increases the acquired enterprise's debt and reduces its equity², posing
24 new financial challenges to previously existing and ongoing health care clinical operations; and
25

26 Whereas, to issue a dividend upon acquisition of a corporation by a PE firm, as is done
27 via “dividend recapitalization”, violates typical capitalistic practices, because in capitalist
28 economies, dividends are typically declared only after a corporation generates profits from its
29 operations; and

30 Whereas, to enable a PE-acquired health care enterprise to retire the debt acquired to enable
31 the practice of Dividend Recapitalization, saddles the acquired enterprise with new debt, and
32 this debt forces service cutbacks and staffing limitations after PE acquisition, direct
33 consequences of reduced equity and increased debt imposed upon the acquired health care
34 enterprise; and

35 Whereas, private equity acquisition of physician practices has been associated with increased
36 physician turnover and workforce instability, reflecting reduced physician morale and burnout-
37 related pressures³, and has also been associated with increased health care spending and
38 higher prices charged to patients following acquisition⁴; and

1 Whereas, typically PE firms cut staffing, equipment, and services, with these staff and service
2 cutbacks associated with patient harms, such as increased death rates⁵; and
3

4 Whereas, these changes made consequent to a dividend recapitalization would not have been
5 advocated by physicians working within the PE-acquired health care enterprise, demonstrating
6 that the requirement to repay this dividend impairs physician autonomy and authority, in direct
7 violation of AMA Policy D-160.904; therefore be it
8

9 RESOLVED, that our American Medical Association will advocate that the practice of Dividend
10 Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity
11 firms or other investors (Directive to Take Action); and be it further
12

13 RESOLVED, that our AMA will develop model federal and state legislation that would prohibit
14 the practice of Dividend Recapitalization when health care enterprises are acquired by PE and
15 other corporations. (Directive to Take Action)
16

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

Received: 4/20/26

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3. Singh Y, Bejarano Cardenas G, Torabzadeh H, et al. Physician turnover increased in private equity-acquired physician practices. Health Affairs. 2025;44(3):280-287.
4. Braun RT, Bond AM, Qian Y, et al. Association of private equity acquisition of physician practices with changes in health care spending and utilization. JAMA Health Forum. 2022;3(9):e222886.
5. Kannan S, Dov Bruch J, Zubizarreta JR. Hospital staffing and patient outcomes after private equity acquisition. Ann Intern Med. 2025;178:1529-38.

RELEVANT AMA POLICY

AMA Policy D-160.904 The Regulation of Private Equity in the Healthcare Sector

Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-26)

Introduced by: American Academy of Emergency Medicine, Florida

Subject: Strengthening Our AMA Efforts Toward CPOM Prohibition

Referred to: Reference Committee B

1 Whereas, AMA Policy H-215.981, Corporate Practice of Medicine, states that the AMA opposes
2 the corporate practice of medicine, supports restriction of ownership and operational authority of
3 physician medical practices to physicians or physician-owned groups, and supports model
4 legislation to protect physician autonomy and patient-centered care; and
5

6 Whereas, AMA Policy H-160.887 recognizes that the corporate practice of medicine can erode
7 the patient-physician relationship and create conflicts between investor profit motives and the
8 ethical practice of medicine; and
9

10 Whereas, AMA Policy H-160.891, Corporate Investors and Other Corporate Entities, addresses
11 physician relationships with corporate investors but does not clearly prohibit ownership and
12 governance structures that allow non-licensed entities to exercise control over clinical practice;
13 and
14

15 Whereas, AMA Code of Medical Ethics Opinion 11.2.3, Contracts to Deliver Health Care
16 Services, states that contracts must not compromise physicians' professional judgment, clinical
17 autonomy, or patient welfare, and that physicians must not enter agreements that prioritize
18 financial interests over patient care; and
19

20 Whereas, Vermont House Bill H.583 (2026)¹ would strengthen restrictions on the corporate
21 practice of medicine by prohibiting unlicensed entities from owning medical practices, requiring
22 that licensed physicians hold majority ownership and voting control of professional medical
23 corporations, and barring corporate interference in clinical decision making; and
24

25 Whereas, Oregon Senate Bill 951 (2025)² strengthens the prohibition against the corporate
26 practice of medicine doctrine by restricting management service organizations and their
27 affiliates from owning or exercising de facto control over physician practice entities, and by
28 prohibiting interference with physician clinical judgment, staffing, compensation, coding, billing,
29 contracting, and other operational decisions that affect patient care; and
30

31 Whereas, these legislative efforts reflect a growing recognition that corporate ownership models
32 and management structures can undermine physician autonomy, distort clinical priorities, and
33 compromise patient trust; and
34

35 Whereas, stronger and more precise AMA policy guidance is needed to align with emerging
36 state laws and to clearly define and restrict corporate practice arrangements that allow non-
37 licensed entities to control or influence medical decision making; therefore be it
38

39 RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion
40 and addition in section 1 as follows:

1 ~~“1. Our American Medical Association encourages physicians who are contemplating corporate~~
2 ~~investor partnerships or corporate entity relationships, including those under ‘friendly’ physician~~
3 ~~professional corporation (PC) arrangements with Management Service Organizations (MSOs),~~
4 ~~to consider the following guidelines: supports policies that preserve physician ownership,~~
5 ~~governance, and independent medical judgment in physician practices and opposes corporate~~
6 ~~ownership or contractual arrangements that permit non-licensed entities to exercise control over~~
7 ~~the practice of medicine.”~~ (Modify Current HOD Policy); and be it further

8
9 RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in the introductory
10 clause preceding subsections (a)–(c) as follows:

11 ~~“Physicians who are contemplating corporate investor partnerships or corporate entity~~
12 ~~relationships Physicians and policymakers evaluating corporate investment in physician~~
13 ~~practices should consider the following principles to ensure that any such relationships remain~~
14 ~~subordinate to physician ownership, governance, and professional medical judgment”~~ (Modify
15 Current HOD Policy); and be it further

16
17 RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (d)
18 as follows:

19 ~~“(d) Physicians should ensure that contractual arrangements preserve physician autonomy in~~
20 ~~clinical decision making. Physician practices delivering medical care should be majority owned~~
21 ~~by licensed physicians who are actively practicing in the entity, and those licensed physicians~~
22 ~~must retain final authority over clinical decision making and over operational and administrative~~
23 ~~decisions that affect patient care, including clinical staffing, scope of services, clinical policies~~
24 ~~and standards, compensation structures tied to clinical services, coding and billing policies,~~
25 ~~payer contracting, and practice governance.”~~ (Modify Current HOD Policy); and be it further

26
27 RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (e)
28 as follows:

29 ~~“(e) Physicians should carefully review contractual provisions governing governance structures,~~
30 ~~compensation arrangements, and management responsibilities when entering relationships with~~
31 ~~corporate investors. Our AMA opposes stock transfer restriction agreements, “friendly PC”~~
32 ~~arrangements, succession rights, compelled sale provisions, management agreements, or other~~
33 ~~contractual mechanisms that permit non-licensed entities to exercise direct or de facto control~~
34 ~~over physician practices or over physicians’ professional medical judgment. Physicians should~~
35 ~~review contractual provisions governing governance structures, compensation arrangements,~~
36 ~~and management responsibilities to ensure that such arrangements do not transfer control of~~
37 ~~clinical decision making, physician employment conditions affecting patient care, or other core~~
38 ~~professional functions to non-licensed entities.”~~ (Modify Current HOD Policy); and be it further

39
40 RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection
41 (f) to read as follows, and renumbering the subsequent subsections accordingly:

42 ~~“(f) Our AMA opposes management services organizations, private equity firms, and other non-~~
43 ~~licensed entities, and their owners, officers, directors, employees, or agents, from exercising~~
44 ~~governance authority or management control within a professional medical entity in a manner~~
45 ~~that directs, controls, or unduly influences clinical decision making, physician employment~~
46 ~~conditions affecting patient care, or other decisions reserved to licensed physicians.”~~ (Modify
47 Current HOD Policy); and be it further

48
49 RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection
50 (g) to read as follows, and renumbering the subsequent subsections accordingly:

51 ~~“(g) Our AMA opposes noncompetition, nondisclosure, non-disparagement, and non-~~
52 ~~interference clauses that restrict a physician’s ability to exercise independent professional~~

1 judgment, advocate for patients, report unsafe or unethical conditions, or continue caring for
2 patients consistent with ethical and legal obligations.” (Modify Current HOD Policy); and be it
3 further
4

5 RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (h)
6 as follows:

7 ~~“(h) Physicians should seek transparency regarding the financial and ownership structures~~
8 ~~associated with corporate investors and related entities. Our AMA supports clear disclosure of~~
9 ~~physician practice ownership, governance, management agreements, and contractual control~~
10 ~~rights so that physicians, patients, regulators, and policymakers can identify who holds financial~~
11 ~~and operational control over the practice entity.”~~ (Modify Current HOD Policy); and be it further
12

13 RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion
14 and addition in item 2 as follows:

15 “2. Physicians should understand and evaluate the financial and governance implications of
16 corporate investment in medical practices ~~before entering such arrangements~~ and ensure that
17 any such arrangements do not transfer ownership, governance authority, or operational control
18 over clinical decision making to non-licensed entities.” (Modify Current HOD Policy)
19

Fiscal Note: Minimal – less than \$5,000

Received: 4/20/26

REFERENCES

1. Vermont House Bill 583 2026. <https://legislature.vermont.gov/Documents/2026/Docs/BILLS/H-0583/H-0583%20As%20Introduced.pdf>
2. Oregon Senate Bill 951 2025. <https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB951/Enrolled>

RELEVANT AMA POLICY

AMA Policy H-215.981, Corporate Practice of Medicine

1. Our AMA vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

AMA Policy H-160.891 Corporate Investors and Other Corporate Entities

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under “friendly” physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
 - a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor/entity.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity’s business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
 - d. Retaining negotiators to advocate for the best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
 - h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
 - j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
 - i. Determining which diagnostic tests are appropriate;
 - ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
 - iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
 - iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
 - v. Determining the content of patient medical records;
 - vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
 - vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
 - viii. Making decisions regarding coding and billing procedures for patient care services; and
 - ix. Approving the selection of medical equipment and medical supplies.
 - k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.

- (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
- (ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
- (iii) ensures the physician can appropriately exercise professional judgment;
- (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
- (v) is transparent and permits disclosure to patients;
- (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
- (vii) prohibits the corporate practice of medicine.

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

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

- (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
- (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
- (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.
- (f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Reducing Emergency Department Boarding through Payment Reform

Referred to: Reference Committee B

1 Whereas, our AMA Policy D-130.957, Addressing and Reducing Patient Boarding in Emergency
2 Departments, recognizes that boarding patients in the emergency department harms patient
3 safety and quality of care but lacks strong mechanisms to support system change; and
4

5 Whereas, boarding of admitted patients in emergency departments delays definitive care,
6 contributes to clinical deterioration, increases medical error risk, reduces throughput capacity,
7 and worsens clinician burnout and system inefficiency; and national clinical guidance identifies
8 boarding times beyond four hours as associated with adverse outcomes¹⁻⁴; and
9

10 Whereas, from a systems perspective, emergency department boarding follows surges in
11 inpatient demand, yet hospital leaders continue to manage their systems by using the
12 emergency department as the system's only "surge absorber", even though other resources to
13 dissipate surge have been described and advocated in peer-reviewed literature⁵⁻⁷; and
14

15 Whereas, the Centers for Medicare & Medicaid Services (CMS) released updated Hospital
16 Outpatient Prospective Payment System quality reporting requirements that include emergency
17 care abstracted clinical quality measures such as median time from ED arrival to departure,
18 initially voluntary with planned transition to mandatory reporting, but do not currently include any
19 payment consequence tied to prolonged boarding times; and reporting of these measures does
20 not itself create financial incentives for hospitals to act¹; and
21

22 Whereas, current reimbursement structures do not adequately incentivize hospitals to reduce
23 boarding, despite evidence that operational inefficiencies and boarding increase costs and
24 strain resources without improving care quality^{2,3}; and
25

26 Whereas, aligning financial incentives with quality outcomes through payment reform is a
27 proven strategy to motivate system improvement and hold institutions accountable for key
28 safety and access metrics; therefore be it
29

30 RESOLVED, that our American Medical Association advocates for the Centers for Medicare &
31 Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to
32 emergency department boarding performance, including payment reductions or creation of a
33 lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to
34 Take Action); and be it further
35

36 RESOLVED, that our AMA adopts policy and advocates for making emergency department
37 boarding metrics mandatory quality measures incorporated into value-based payment
38 programs, rather than reporting-only requirements without financial consequence. (Directive to
39 Take Action)
40

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

Received: 4/20/26

REFERENCES

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2. American College of Emergency Physicians. Emergency Department Crowding and Boarding. Ann Emerg Med. Various publications summarizing boarding >4 hours as a quality concern.
3. Office of Inspector General, U.S. Department of Health and Human Services. Hospital Emergency Department Crowding and Boarding of Admitted Patients. OEI-02-21-00320. Published 2022.
4. Agency for Healthcare Research and Quality. Emergency Department Crowding and Patient Safety. AHRQ Publication.
5. Viccellio, P., et al. Patients Overwhelmingly Prefer Inpatient Boarding to Emergency Department Boarding. Journal of Emergency Medicine. Volume 45, Issue 6, P942-946. December 2013. [https://www.jem-journal.com/article/S0736-4679\(13\)00826-3/abstract](https://www.jem-journal.com/article/S0736-4679(13)00826-3/abstract)
6. Litvak E, Bisognano M. More patients, less payment: increasing hospital efficiency in the aftermath of health reform. Health Aff (Millwood). 2011;30(1):76-80.
7. Hoot NR, Aronsky D. Systematic review of emergency department crowding: causes, effects, and solutions. Ann Emerg Med. 2008;52(2):126-136.

RELEVANT AMA POLICY

D-130.957 Addressing and Reducing Patient Boarding in Emergency Departments

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-26)

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

Subject: Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions

Referred to: Reference Committee B

1 Whereas, federal mandates under Public Law No. 119-21 (the enacted version of H.R. 1)
2 require the District of Columbia and the 40 states that have expanded Medicaid to implement
3 community engagement or work requirements by January 1, 2027; and
4

5 Whereas, our American Medical Association's (AMA) Policy H-290.963 supports robust
6 exemptions for individuals who are "medically frail" or have "serious or complex medical
7 conditions," yet these terms lack a uniform clinical definition across the Centers for Medicare &
8 Medicaid Services (CMS) and state Medicaid agencies; and
9

10 Whereas, our AMA has advocated for federal and state policies that protect vulnerable
11 populations, specifically urging CMS to ensure that mandatory 'medical frailty' exemptions
12 include individuals with cancer, heart disease, or other chronic and severe conditions to prevent
13 them from falling through the cracks of new community engagement requirements; and
14

15 Whereas, Public Law No. 119-21 defines an individual who is "medically frail or otherwise has
16 special medical needs (as defined by the Secretary)" as one who is "blind or disabled (as
17 defined in section 1614); with a substance use disorder; with a disabling mental disorder; with a
18 physical, intellectual, or developmental disability that significantly impairs their ability to perform
19 1 or more activities of daily living; or with a serious or complex medical condition"; and
20

21 Whereas, the absence of explicit exemption language across Medicaid programs creates
22 administrative barriers that jeopardize coverage for patients in critical phases of care, such as
23 diagnostic testing, active treatment, long-term surveillance or monitoring, and survivorship; and
24

25 Whereas, patients living with complex medical conditions—including but not limited to cancer,
26 end-stage renal disease, advanced cardiovascular disease, and other conditions across
27 medical, surgical, and psychiatric domains—face intense treatment regimens and physical
28 limitations that make meeting work requirements both practically unfeasible and a risk to their
29 health; and
30

31 Whereas, a patient's recovery and stability often rest on the shoulders of a primary caregiver,
32 whose vital role is undermined when work mandates threaten the caregiver's own health
33 coverage and the stability of the household; and
34

35 Whereas, moreover, the absence of clear, standardized exemption criteria may compel
36 physicians to repeatedly justify medical frailty through burdensome documentation processes,
37 adding uncompensated administrative workload; therefore be it

1 RESOLVED, that our American Medical Association advocate that the Centers for Medicare &
2 Medicaid Services and state Medicaid agencies establish a standard with which to define
3 "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies;
4 this definition shall explicitly include, at a minimum, any individual currently undergoing
5 diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a
6 life-threatening or complex chronic medical condition, as well as conditions in which the disease
7 or its treatment results in functional limitation or an ongoing need for medical care, while
8 preserving the authority of states to expand these protections to additional populations
9 (Directive to Take Action); and be it further

10
11 RESOLVED, that our AMA advocate for federal and state Medicaid guidance to provide
12 automatic exemptions from community engagement and work requirements for patients and
13 primary caregivers of patients with complex medical conditions, utilizing evidence-based clinical
14 data and claims-based algorithms to ensure treatment adherence and continuity of care
15 (Directive to Take Action); and be it further

16
17 RESOLVED, that our AMA advocate for streamlined Medicaid community engagement and
18 work requirement exemption verification by minimizing administrative burden for patients and
19 physicians. (Directive to Take Action)

20
Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 4/20/26

REFERENCES

1. American Society of Clinical Oncology. 2026 ASCO Position Statement: Implications for Cancer Care in a New Medicaid Era. Published March 2, 2026. <https://cdn.bfldr.com/KOIH2Q3/as/hs3j3rxr3ccjt44cmvpg96/2026-ASCO-Medicaid-Position-Statement>
2. Association for Clinical Oncology. Medicaid. Advocacy Agenda & Initiatives. April 2026. <https://www.asco.org/get-involved/advocacy/advocacy-agenda-initiatives/medicaid>
3. American Medical Association. Letter to Daniel Brillman, Director, Center for Medicaid & CHIP Services, Re: Implementation of Medicaid Community Engagement Requirements. March 9, 2026.
4. KFF. Tracking Implementation of the 2025 Reconciliation Law: Medicaid Work Requirements. Published March 6, 2026. <https://www.kff.org/medicaid/medicaid-work-requirements-tracker-overview>

RELEVANT AMA POLICY

H-290.963 Federal Medicaid Funding

Our AMA will advocate that any Medicaid community engagement or work requirements include clear and robust processes to appropriately exempt individuals who are medically frail or have serious or complex medical conditions. [CMS Rep. 05, I-17; Reaffirmed: CMS Rep. 05, A-22]

H-290.965 Affordable Care Act Medicaid Expansion

Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents. [CMS Rep. 2, A-14; Reaffirmed: CMS Rep. 05, A-22]

H-55.969 Cancer Survivorship Care Plans

Our AMA (1) recognizes that cancer survivorship care is a distinct and vital component of the cancer care continuum and (2) supports the development and use of survivorship care plans to improve the quality of care for cancer survivors. [Res. 518, A-11; Reaffirmed: CSAPH Rep. 01, A-21]

D-290.979 Affordable Care Act Medicaid Expansion

Our AMA will support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act and will advocate for the maintenance of the vital safety net provided by the Medicaid program. [CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 5, I-20]

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 244
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Eliminate Administrative Barriers to Appeal Wrongful Denials

Referred to: Reference Committee B

1 Whereas, health plans and insurance companies impose unreasonable burdens to appeal claim
2 and services denials by requiring submission of redundant forms and fail to honor consent forms
3 and authorizations signed by a patient; and
4

5 Whereas, for out-of-network providers in particular, many health plans demand that a separate
6 “designation of authorized representative” form be filled out by a patient, long after the patient is
7 gone, to appeal claim denials and when a patient switches a plan, a new form has to be filed
8 even as patients expect, demand, and have previously authorized physicians to appeal on their
9 behalf promptly and without imposing administrative burdens on patients; and
10

11 Whereas, health plans fail to honor previously signed generic “designation of authorized
12 representative” forms; and
13

14 Whereas, the United States Department of Labor is authorized to regulate the claims procedure
15 under Title 29 of the U.S. Code¹; therefore be it
16

17 RESOLVED, that our American Medical Association advocates to the United States Department
18 of Labor to issue regulations to require that health plans honor signed patients’ designations to
19 submit and appeal plans without requiring plan-specific forms (Directive to Take Action); and be
20 it further
21

22 RESOLVED, that our AMA advocates that the US Department of Labor does not require
23 additional and separate consent from the patient in order for a physician practice to file a
24 complaint with the US Department of Labor against self-funded ERISA plans once the patient
25 has assigned benefits to the physician. (Directive to Take Action)
26

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

Received: 4/20/26

REFERENCES

1. 29 CFR § 2560.503-1 - Claims procedure. <https://www.law.cornell.edu/cfr/text/29/2560.503-1>. Accessed April 8, 2026.

RELEVANT AMA POLICY

Medicare Advantage Plans Double Standard H-330.863

Our AMA will seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor.

Citation: Res. 109, A-25

Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals D-120.959

Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals D-120.959

Citation: Res. 212, A-08; Reaffirmed: BOT Rep. 04, A-20

Insurance Coverage Appeals D-320.993

Our AMA will:

- (1) continue to support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;
- (2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;
- (3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;
- (4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;
- (5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and
- (6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations.

Citation: BOT Rep. 23, A-06; Modified: CMS Rep. 01, A-16; Reaffirmed: I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-26)

Introduced by: Private Practice Physicians Section

Subject: State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—
Rutledge v. PCMA

Referred to: Reference Committee (Assigned by HOD)

1 Whereas, AMA policy D-385.944, “ERISA Preemption of State Laws Regulating Pharmacy
2 Benefit Managers”¹ seeks to support states in implementation of state-based regulation of
3 ERISA plans to the extent allowed by the U.S. Supreme Court decision in *Rutledge v. PCMA*;
4 and

5
6 Whereas, the Employee Retirement Income Security Act (ERISA) does not address interest
7 payments on overdue “clean” health insurance claims and many states such as New York have
8 laws in place that require health plans to pay interest²; and

9
10 Whereas, ERISA does not address timeliness of response to prior authorization requirements,
11 duty to obtain data that is available to health plans from sources other than physicians that
12 health plans may need for prior authorization (test results, list of current medications); and

13
14 Whereas, ERISA does not address payments for services based on the coordination of benefits,
15 requiring a health plan to pay at the in-network level of benefits for covered services when it is
16 secondary to Medicare and the provider is a Medicare-participating provider, and secondary
17 Medicare payments are not regulated under Medicare; and

18
19 Whereas, AMA policy D-320.978, “Fair Reimbursement for Administrative Burdens”³ states that
20 physicians should be fairly compensated for administrative work related to prior authorization,
21 appeals of prior authorization denials, and appealing wrongful pre- and post-service denials for
22 administrative work reflecting the actual time expended by physician practices and their billing
23 vendors advocating on behalf of patients, complying with insurer requirements, and successfully
24 appealing wrongful service denials; despite AMA policy, ERISA does not address prior
25 authorization or compensation for the administrative work associated with prior authorizations or
26 compensation for various administrative burdens associated with prior authorizations; and

27
28 Whereas, ERISA does not address parity for telehealth-assisted services, which may also be
29 delivered using virtual reality in the future, nor does it refer to the site of service or technology
30 used for care delivery, likewise, it does not address compensation for treatment of conditions
31 that are already covered and the same medical services for the same conditions are delivered
32 when appropriate via telehealth and in-person; and

33
34 Whereas, ERISA requires a plan administrator to make a claims decision “within a reasonable
35 period of time, but not later than 30 days after receipt of the claim,” but there is no regulation of
36 the timeliness of the payment for the claim⁴; further, states like New York require⁵ health plans
37 to pay claims within 30 days “when the insurer’s obligation to pay the claim is reasonably clear”
38 and applying similar requirements to ERISA plans would significantly improve the sustainability
39 and financial viability of physician practices; and

1 ERISA does not address payment recovery or recoupment by health plans and IRS regulations
2 are separate from ERISA and allow recoupment from any third party (participant, another plan,
3 etc.) or the plan must pay in for its own mistakes; therefore be it
4

5 RESOLVED, that our American Medical Association will examine the strategic and operational
6 opportunities physicians should consider under the U.S. Supreme Court holding in *Rutledge v.*
7 *PCMA* as they pertain to the Employment Retirement Income Security Act (ERISA) with a report
8 back at the Annual 2027 meeting with recommendations for operational best practices (Directive
9 to Take Action); and be it further

10
11 RESOLVED, that our AMA will explore and, as appropriate, provide related educational
12 programming at Interim and/or Annual Meetings and through other appropriate venues,
13 including potential educational modules, regarding ERISA and its practical implications for
14 private practice physicians (Directive to Take Action); and be it further
15

16 RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of
17 amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways
18 that can eliminate problems that some independent physicians experience, including:

- 19 1. Interest payments on overdue “clean” health insurance claims not otherwise
20 addressed by ERISA’s statutory mandate;
- 21 2. Administrative issues surrounding prior authorization, including but not limited to
22 timeliness of responses and duty to obtain data records available from sources
23 other than the physician so as not to waste physician resources;
- 24 3. Payment for Medicare co-insurance and deductibles when Medicare is primary and
25 another plan is secondary and the physician is a Medicare-participating physician
26 but non-participating with the secondary plan;
- 27 4. Payment for the administrative burden of prior authorization and successful denial
28 appeals;
- 29 5. Parity for telehealth-delivered services;
- 30 6. Timely payment of “clean claims” when the insurer’s obligation to pay the claim is
31 reasonably distinct from timely determination of claims;
- 32 7. Enforcement of evaluation & management modifier code 25 use/payments as
33 articulated under AMA policies D-385.956 and D-70.971 as well as analogous state
34 medical society policies;
- 35 8. Requiring that when health plan payment recovery or recoupment is due to
36 coordination of benefit failure, the health plan shall seek recovery from the patient
37 and/or the correct payor.

38 (Directive to Take Action)
39

Fiscal Note: Major – \$127,219. Legal analysis, creation of educational programming/modules.

Received: 4/20/26

REFERENCES

1. ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (D-385.944), American Medical Association.
2. Office of the General Counsel of the Department of Financial Services of New York State. (2001). Opinion re: health claims interest rate. <https://www.dfs.ny.gov/insurance/ogco2001/rq110231.htm>
3. Fair Reimbursement for Administrative Burdens (D-320.978). American Medical Association
4. Employee Benefits Security Administration. Benefits claims procedure regulation FAQs. US Department of Labor. Accessed March 13, 2025: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation>
5. Department of Financial Services. (2021, March 15). Governor Cuomo announces new guidance for the Department of Financial Services for the fair and prompt payment of health insurance claims. State of New York. Accessed March 13, 2025: https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202103151
6. Opposition to Reduced Payment for the 25 Modifier (D-385.956). American Medical Association.

RELEVANT AMA POLICY

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944

Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.

Citation: Res. 224, I-23

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
 - a. the prior authorization process.
 - b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22

Opposition to Reduced Payment for the 25 Modifier D-385.956

Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.

Citation: Res. 808, I-17; Reaffirmed: CMS Rep. 07, A-23

Uses and Abuses of CPT Modifier -25 D-70.971

1. Our American Medical Association Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.
2. The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.
3. Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.
4. Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.
5. Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.
6. Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.
7. Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.
8. Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

Citation: BOT Rep. 10, I-03; Reaffirmed: A-10; Reaffirmed: A-19; Reaffirmed: CMS Rep. 07, A-23

Remuneration for Physician Services H-385.951

1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed; A-11; Reaffirmed in lieu of: Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed; 811, I-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 30, A-24; Reaffirmed: BOT I-24; Reaffirmed: Res. 801, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Artificial Intelligence Scope of Practice

Referred to: Reference Committee B

1 Whereas, artificial/augmented intelligence (AI) can assist with the transformation of healthcare
2 by enhancing diagnostic capabilities through tools like remote patient monitoring and automated
3 administrative tasks; and
4

5 Whereas, AI can provide accessible health education to patient through online platforms and
6 apps; and
7

8 Whereas, AI can assist primary care physicians providing rural care for data analysis,
9 leveraging large datasets to provide care similar to that available in urban centers; and
10

11 Whereas, the “Healthy Technology Act of 2025” (H.R. 238) has been introduced in the United
12 State House of Representatives to explore the possibility of allowing Food and Drug
13 Administration-approved AI to prescribe drugs; and
14

15 Whereas, Doctronic, a Utah technology company in partnership with the Utah Office of Artificial
16 intelligence Policy, gained authority under a pilot project for artificial intelligence to renew
17 prescriptions independently¹; and
18

19 Whereas, Cicero, a policy entity in Austin, Texas, has created model legislation for an
20 autonomous artificial intelligence provider²; and
21

22 Whereas, the One Big Beautiful Bill that passed the U.S. House of Representatives approved a
23 10-year moratorium on state AI legislation that was not included in the version passed by the
24 U.S. Senate³; and
25

26 Whereas, Executive Order 14179 restores government control over artificial intelligence and
27 imposing limitations on states’ rights to develop and implement laws relating to artificial
28 intelligence⁴; therefore be it
29

30 RESOLVED, that our American Medical Association will develop model legislation declaring that
31 artificial intelligence will not be used as a prescriptive or care management substitute for a
32 physician (Directive to Take Action); and be it further
33

34 RESOLVED, that our AMA will develop model legislation prohibiting the Federation of State
35 Medical Boards from enabling independent licensure be granted to artificial intelligence
36 “providers.” (Directive to Take Action)
37

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

Received: 4/20/26

REFERENCES

1. Doctronic raises \$20 million series A to bring private and personalized AI doctor to the masses. (2025). *Healthcare IT Today*. October 22, 2025. Accessed March 23, 2026: <https://www.healthcareittoday.com/2025/10/22/doctronic-raises-20-million-series-a-to-bring-private-and-personalized-ai-doctor-to-the-masses/>.
2. Cicero Institute. The AI Medical Service Act. <https://ciceroinstitute.org/wp-content/uploads/2026/01/AI-Medical-Services-Act-Model-Bill.pdf>. Accessed March 23, 2026.
3. An Act to Provide for Reconciliation Pursuant to Title II of H.Con.Res.14, 139 Stat. 72, PL 119-21. (2025). <https://www.congress.gov/bill/119th-congress/house-bill/1/text?s=1&r=1&hl=one+big+beautiful+bill>. Accessed March 23, 2026.
4. Executive Order 14365, FR Doc 2025-23092. (2025). <https://www.whitehouse.gov/presidential-actions/2025/12/eliminating-state-law-obstruction-of-national-artificial-intelligence-policy>. Accessed March 23, 2026.

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25.

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing

- patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
 - a. clinical validation.
 - b. alignment with clinical decision-making that is familiar to physicians.
 - c. high-quality clinical evidence.
 4. Payment and coverage for health care AI systems must
 - a. be informed by real world workflow and human-centered design principles.
 - b. enable physicians to prepare for and transition to new care delivery models.
 - c. support effective communication and engagement between patients, physicians, and the health care team.
 - d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
 - e. seek end-user feedback to support iterative product improvement.
 5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
 6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
 - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
 - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
 - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
 - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
 8. Our AMA, national medical specialty societies, and state medical associations:
 - a. Identify areas of medical practice where AI systems would advance the quadruple aim.
 - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
 - c. Outline new professional roles and capacities required to aid and guide health care AI systems.
 - d. Develop practice guidelines for clinical applications of AI systems.
 9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
 10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Assessing the Intersection Between AI and Health Care H-480.931

Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
 - a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
 - b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
 - c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
 - d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
 - e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
 - f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
 - g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
 - h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
 - i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
 - a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
 - i. AI disclosure should align and meet ethical standards or norms.
 - ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
 - iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request

- additional review from a licensed clinician should be made available upon request.
- iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
 - b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
 - c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
 - d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
- a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
 - i. Regulatory approval status.
 - ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
 - iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
 - iv. Intended population and intended practice setting.
 - v. Clear description of any limitations or risks for use, including possible disparate impact.
 - vi. Description of how impacted populations were engaged during the AI lifecycle.
 - vii. Detailed information regarding data used to train the model:
 1. Data provenance.
 2. Data size and completeness.
 3. Data timeframes.
 4. Data diversity.
 5. Data labeling accuracy.
 - viii. Validation Data/Information and evidence of:
 1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
 2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
 3. Algorithmic validation.
 4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
 5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
 6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
 7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
 - ix. Data Use Policy:
 1. Privacy.
 2. Security.
 3. Special considerations for protected populations or groups put at increased risk.
 - x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

- xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
 - b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]
- 4. Generative Augmented Intelligence
 - a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
 - b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
 - i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
 - ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
 - iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
 - iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
 - v. Data privacy.
 - vi. Cybersecurity.
 - vii. Physician liability associated with the use of generative AI tools.
 - c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
 - d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
 - e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
 - f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.
- 5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
 - a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
 - i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

- iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
 - b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
 - c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
- 6. Data Privacy and Augmented Intelligence
 - a. Entity Responsibility:
 - i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
 - ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
 - iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
 - b. User Education:
 - i. Users should be provided with training specifically on generative AI. Education should address:
 - 1. Legal, ethical, and equity considerations.
 - 2. Risks such as data breaches and re-identification.
 - 3. Potential pitfalls of inputting sensitive and personal data.
 - 4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

- 7. Augmented Intelligence Cybersecurity
 - a. AI systems must have strong protections against input manipulation and malicious attacks.
 - b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
 - c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
 - d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
- 8. Mitigating Misinformation in AI-Enabled Technologies
 - a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
 - b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
 - c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
 - d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising

directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

- e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
- f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems

so that they can be monitored for negative and disparate impacts on access to care.
Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve:
Res. 226, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247
(A-26)

Introduced by: Texas

Subject: Comprehensive ERISA Reform

Referred to: Reference Committee B

1 Whereas, self-insured plans are regulated at the federal level by the Employee Retirement
2 Income Security Act (ERISA) and are exempt from most state insurance laws, rules, and
3 oversight; and
4

5 Whereas, according to a 2024 study by the Kaiser Family Foundation, approximately 63% of
6 workers under the age of 65 are enrolled in self-insured health plans; and
7

8 Whereas, ERISA provides minimal federal regulatory protections for physicians and patients
9 enrolled in self-insured plans from burdensome, inconsistent, or egregious payer policies; and
10

11 Whereas, while Texas enforced prompt pay regulations for fully insured (state regulated) health
12 plans, there are few, if any, comparable federal prompt pay protections under ERISA for self-
13 insured plans; and
14

15 Whereas, Texas law places limits on the timeframe during which insurers can request refunds
16 or make payment recoupments under state-regulated plans, yet such consumer and provider
17 protections are largely absent under ERISA for self-insured plans; and
18

19 Whereas, Texas imposes standards on prepayment claims audits for fully insured plans, but no
20 equivalent federal standards exist under ERISA for self-insured plans; and
21

22 Whereas, Texas has implemented regulations regarding prior authorization processes and
23 timelines for state-regulated plans, but these protections do not apply to self-insured plans
24 governed by ERISA; and
25

26 Whereas, Title 29, Chapter 18, subchapter I, Part 5 of ERISA (29 US Code § 1144) broadly
27 preempts “any and all State laws” insofar as they “relate to” employee benefit plans, and
28 repeated efforts to eliminate or narrow this preemption have been unsuccessful; and
29

30 Whereas, among all states, Texas has implemented the most comprehensive laws addressing
31 prompt payment requirements, refund and recoupment timeframes, prepayment claims audit
32 standards, and prior authorization processes; therefore be it
33

34 RESOLVED, that our American Medical Association support federal regulation and/or legislation
35 under ERISA to establish rules for prompt payment, refund and recoupment timelines,
36 prepayment claims audits, penalties, and related matters, and that such be modeled after the
37 Texas Prompt Pay laws and rules, requiring a report back at the following annual meeting.
38 (New HOD Policy)
39

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

Received: 4/20/26

REFERENCES

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2. Title 29, Chapter 18, Part 5 of ERISA (29 US Code § 1144). House.gov. Published 2024. Accessed April 20, 2026. [https://uscode.house.gov/view.xhtml?req=\(title:29%20section:1144%20edition:prelim\)%20OR%20\(granuleid:USC-prelim-title29-section1144\)&f=treesort&edition=prelim&num=0&jumpTo=true](https://uscode.house.gov/view.xhtml?req=(title:29%20section:1144%20edition:prelim)%20OR%20(granuleid:USC-prelim-title29-section1144)&f=treesort&edition=prelim&num=0&jumpTo=true)
3. Texas Administrative Code, Title 28, Part 1, Chapter 11 – Health Maintenance Organizations, Subchapter J – Physician and Provider Contracts and Arrangements §11.900 – 11.904. Appianportalsgov.com. Published 2026. Accessed April 20, 2026. https://texas40.sos.appianportalsgov.com/rules-and41meetings?chapter=11&interface=VIEW_TAC&part=1&subchapter=J&title=28

RELEVANT AMA POLICY

- [Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926](#)
- [Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959](#)
- [Insurance Reimbursements D-190.977](#)
- [Required Clinical Qualifications on Determining Medical Diagnoses and Medical Necessity D-320.975](#)
- [Additional Prompt Payment Advocacy H-385-927](#)
- [Insurance Companies Use of Contractors to Recover Payments D-385.965](#)
- [Payment for Pre-Certified/Preauthorized Procedures H-385.900](#)
- [Medical Office Screens H-335.981](#)
- [Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims H-385.967](#)
- [AMA Policy on ERISA H-285.915](#)
- [ERISA Preemption and State Prompt Pay Laws D-385.984](#)
- [ERISA and Managed Care Oversight D-383.984](#)
- [Time Sensitive Credentialing of New Providers with an Insurance Carrier D-285.956](#)
- [ERISA and Health Plan Related Legislation D-190.996](#)
- [ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944](#)