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PRIVATE PRACTICE PHYSICIANS SECTION
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Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Items highlighted in blue have been recommended for reaffirmation.
Items highlighted in red are items of interest for monitoring and have no current GC recommendation.

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1	E&B	CEJA 01 – Guidelines on Chaperones for Sensitive Exams	RECOMMENDATION The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed: 1. Opinion 1.2.4 "Use of Chaperones" be amended by deletion and addition as follows: <u>Chaperones should be authorized members of the health care team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.</u> <u>Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients.</u> ~~Efforts to provide a comfortable and considerate atmosphere~~	Delegate instructed to Listen/Monitor.

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			~~for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clearly explaining various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, Physicians should: (a) Provide a chaperone for all sensitive exams, regardless of patient capacity, unless the delay in obtaining a chaperone would result in significant harm to the patient. (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam. i. If the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician. ii. In emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale. ~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~ ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~ ~~(e)~~(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present. (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries. (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a	

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			parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician. All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk. For non-sensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request. (Modify HOD/CEJA Policy) 2. Policy D-140.950 be rescinded as it has been accomplished by this report. (Rescind AMA Policy)	
2	E&B	CEJA 02 – Managing Conflict of Interest Inherent in New Payment Models	The Council on Ethical and Judicial affairs recommends that Policy D-140.946 be rescinded as having been accomplished by this report.	Delegate instructed to support.
3	E&B	CEJA 03 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	RECOMMENDATIONS The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should	Delegate instructed to support.

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			not put the wellbeing of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care.~~ Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice. Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.	

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			(i) Physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care. (ii) Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture. (iii) Physicians should avoid disruptive collective actions that could directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest. (c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients. (d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities. 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)	
4	A	BOT 23 – Liberalized Remorse Period for Medicare Advantage Plans Insureds	RECOMMENDATIONS The Board of Trustees recommends that the following be adopted in lieu of Resolution 117-A-25 and the remainder of the report be filed: 1) That our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services to create a comprehensive strategy to educate people approaching the age of Medicare eligibility and for annual enrollment periods about key aspects of Medicare affecting choices between traditional Medicare and Medicare Advantage (MA) plans. (Directive to Take Action) 2) That our AMA support a Medicare policy that allows beneficiaries who enroll in MA for the first time to disenroll for any reason and return to traditional Medicare within the first 12 months of enrollment in the plan. (New HOD Policy)	Delegate instructed to support.

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			3) That our AMA reaffirm Policy H-330.866, “Medigap Patient Protections.” (Reaffirm HOD Policy)	
5	A	Res. 105 – Oppose Medicare Advantage Auto Enrollment (New York)	RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option. (New HOD Policy)	Delegate instructed to support.
6	A	Res. 107 – Oversight of Medicare Advantage Plan (Indiana)	RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare (New HOD Policy) RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient’s physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions (Directive to Take Action) RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care (New HOD Policy); RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks (Directive to Take Action) RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare. (New HOD Policy)	Delegate instructed to monitor.

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7	A	Res. 108 – Ensuring Physician Input in the Development of CMMI Models (Integrated Physician Practice Section)	RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)	Delegate instructed to monitor.
8	A	Res. 117 – Universal Out of Network Benefits (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will advocate for state and federal laws and regulations that require all insurers to offer plans that include out-of-network benefits. (Directive to Take Action)	Delegate instructed to strongly support.
9	B	BOT 19 – Root Cause Analysis of the Causes of the Decline of Private Medical Practice	The Board of Trustees recommends the following be adopted and the remainder of this report be filed: 1. That our AMA reaffirm the following policies: a. H-330.932, "Cuts in Medicare and Medicaid Reimbursement"; b. H-400.957, "Medicare Reimbursement of Office-Based Procedures"; c. H-390.879, "Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service"; d. D-330.902, "The Site-of-Service Differential"; e. H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service"; f. D-240.994, "Payment Variations Across Outpatient Sites of Service"; D-330.997, "Appropriate Payment Level Differences by Place and Type of Service"; g. D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule"; h. H-385.921, "Health Care Access for Medicaid Patients"; i. D-160.907, "Health System Consolidation"; j. D-215.984, "Health System Consolidation"; k. H-180.947, "Maintaining Freedom of Choice with Insurance Products";	Delegate instructed to support.

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			l. D-160.906, “Strengthening Efforts Against Horizontal & Vertical Consolidation”; m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”; n. D-385.940, “Stark Law Self-Referral Ban”; o. H-215.960, “Hospital Consolidation”; p. H-215.969, “Hospital Merger Study”; q. D-225.995, “Hospital Merger Study”; r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”; s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”; t. H-160.960, “Corporate Ownership of Established Private Medical Practices”; u. D-405.988, “The Preservation of the Private Practice of Medicine”; v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”; w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”; x. H-110.985, "340B Drug Discount Program"; and y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy) 2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy) 3. That Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice” be rescinded as being accomplished by this report. (Rescind HOD Policy)	
10	B	BOT 25 – Federal Legislation to Prohibit the Corporate Practice of Medicine	The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the remainder of this report be filed: 1. That the American Medical Association, in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws. (New HOD Policy)	Delegate instructed to support.

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			2. That the AMA support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency. (New HOD Policy) 3. That the AMA support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine (New HOD Policy) 4. That Policy H-215.981, “Corporate Practice of Medicine,” be amended by addition and deletion as follows: 1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine. 1.2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine. 2.3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. 3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.	

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			4.5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. 5.6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected. 6.7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices. 7.8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected. 8.9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify Current HOD Policy)	
11	B	BOT 27 – Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification	The Board of Trustees recommends the following be adopted and the remainder of the report be filed. 1. That Policy D-190.965 be amended to read as follows: Our American Medical Association report at the Annual 2026~~6~~7 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Update HOD Policy)	Delegate instructed to support.

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		Requirements by CMS	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)	
12	B	Res. 211 – Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians (Mississippi)	RESOLVED, that our American Medical Association advocate for the patients of any physician practicing in the same county (or equivalent region) that contains a covered 340B entity to receive reduced cost medications under the 340b program through the covered entity’s contracted pharmacy. (Directive to Take Action)	Delegate instructed to support.
13	B	Res. 213 – Prohibiting Pharmacy Benefit Managers from Owning Pharmacies (New England)	RESOLVED, that our American Medical Association develop model state legislation empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies. (Directive to Take Action)	Delegate instructed to support.
14	B	Res. 223 – Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations (Georgia)	RESOLVED, that our American Medical Association oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or limitations of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients (New HOD Policy); and be it further RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems (Directive to Take Action); and be it further	Delegate instructed to support.

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			RESOLVED, that our AMA advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance determination, including an explanation of the role of the system in the decision, in both coverage determinations and eligibility, underwriting, or enrollment decisions (Directive to Take Action); and be it further RESOLVED, that our AMA support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular attention to applicant-facing eligibility, underwriting, and enrollment decisions. (Directive to Take Action)	
15	B	Res. 238 – Prohibiting the Independent Practice of Medicine by Artificial Intelligence (Texas)	RESOLVED, that our American Medical Association advocate for legislation and regulation prohibiting the use of artificial intelligence (AI) as an independent diagnostic or prescriptive tool or as a care management substitute for a physician. (Directive to Take Action)	Delegate instructed to support.
16	B	Res. 244 – Eliminate Administrative Barriers to Appeal Wrongful Denials	RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal plans without requiring plan-specific forms (Directive to Take Action); and be it further	Delegate instructed to strongly support.

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		(Private Practice Physicians Section)	RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)	
17	B	Res. 245 – State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices (Directive to Take Action); and be it further RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians (Directive to Take Action); and be it further RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including: 1. Interest payments on overdue “clean” health insurance claims not otherwise addressed by ERISA’s statutory mandate; 2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources; 3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan; 4. Payment for the administrative burden of prior authorization and successful denial appeals; 5. Parity for telehealth-delivered services; 6. Timely payment of “clean claims” when the insurer’s obligation to pay the claim is	Delegate instructed to strongly support.

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			reasonably distinct from timely determination of claims; 7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies; 8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor. (Directive to Take Action)	
18	B	Res. 246 – Artificial Intelligence Scope of Practice (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will develop model legislation declaring that artificial intelligence will not be used as a prescriptive or care management substitute for a physician (Directive to Take Action); and be it further RESOLVED, that our AMA will develop model legislation prohibiting the Federation of State Medical Boards from enabling independent licensure be granted to artificial intelligence "providers." (Directive to Take Action)	Delegate instructed to strongly support.
19	B	Res. 247 – Comprehensive ERISA Reform (Texas)	RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after the Texas Prompt Pay laws and rules, requiring a report back at the following annual meeting. (New HOD Policy)	Delegate instructed to support.
20	D	Res. 434 – Vaccinations in Physician Offices (Private Practice Physicians Section)	RESOLVED, that our American Medical Association advocate for all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines to be covered by Medicare Part B. (Directive to Take Action)	Delegate instructed to strongly support.
21	E	Res. 505 – Avoiding Misuse of Artificial Intelligence (AI) in Clinical Practice	RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document (New HOD Policy); and be it further	Delegate instructed to support.

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		(New York)	RESOLVED, that any physician or healthcare professional, who chooses to use Artificial Intelligence (AI) in the creation of the medical record, understands that the accuracy of that record is completely the responsibility of that author. (New HOD Policy)	
22	E	Res. 515 – Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure (Association for Clinical Oncology)	RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians with the specific clinical logic, evidence-based sources, and version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited to ensure it reflects the most recent peer-reviewed clinical guidelines and recognized standards of care. (Directive to Take Action)	Delegate instructed to support.
23	G	Res. 701 – The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will advocate for the immediate discontinuation of required participation in value-based programs (VBP) arrangements for practices with ten or fewer physicians, regardless of practice revenue. (Directive to Take Action)	Delegate instructed to strongly support.
24	G	Res. 702 – Physicians Who Do Not Practice in Hospital Setting (Pennsylvania)	RESOLVED, that our American Medical Association amend D-230-981 as follows: 1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.	Delegate instructed to strongly support.

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			2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices. 3. <u>Our AMA advocate that hospital privileges not be a requirement for insurance network participation.</u> (Modify Current HOD Policy)	
25	G	Res. 703 – Parity in Pricing for Anti-Obesity Medications (Obesity Medicine Association)	RESOLVED, that our American Medical Association actively oppose preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care. (Directive to Take Action)	Delegate instructed to strongly support.
26	G	Res. 704 – Advocating Against Automatic Refill Requests (Mississippi)	RESOLVED, that our American Medical Association communicate effectively with large pharmacy chains and conglomerates for the purpose of explaining the unnecessary administrative burden of automatic, non-patient-initiated refill requests and petitioning them to require all medication refill requests use a patient directed “opt-in” approach (Directive to Take Action); and be it further RESOLVED, that our AMA petition the Centers for Medicare and Medicaid Services to restrict participating pharmacies from sending medication refill requests to physicians unless the patient “opts-in” to using the refill request. (Directive to Take Action)	Delegate instructed to strongly support.
27	G	Res. 707 – Malpractice Insurance for Employed Physicians (New York)	RESOLVED, that our American Medical Association support a requirement for employers to purchase only occurrence malpractice insurance policies for their employed physicians, fellows and residents. (New HOD Policy)	Delegate instructed to refer and ask for consideration of how this would effect small, independent practices’ finances.
28	G	Res. 708 – Oppose Imposition of Fees on Physicians for	RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rules compliant with the Administrative Procedure Act with a notice and comment period preventing the use of	Delegate instructed to support.

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		Electronic Payment Transfers (New York)	virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)	
29	G	Res. 715 – Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment Under HIPAA (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will advocate that a vendor or clearinghouse that offers a multi-payer platform may not create separate payer-specific enrollment mechanisms into standard adopted HIPAA transactions (Directive to Take Action); and be it further RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic transactions that unnecessarily create duplicate administrative work for physician practices by creating a separate mechanism of enrollment in the same standard transaction for different health plans. (Directive to Take Action)	Delegate instructed to strongly support.
30	G	Res. 716 – Equal Opportunity for Payment for "On Call" Duty (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will work with relevant stakeholders to advocate that all physicians, whether employed or independent, should be paid for "on call" responsibilities, whether or not patient care is separately billed. (Directive to Take Action)	Delegate instructed to strongly support.
31	G	Res. 717 – Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse (Private Practice Physicians Section)	RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan (Directive to Take Action); and be it further RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier	Delegate instructed to strongly support; item to be raised with Assembly at A-26 Business Meeting after preliminary HOD Ref Com Reports release their recommendation for it.

PRIVATE PRACTICE PHYSICIANS SECTION
Governing Council Report A
Annual 2026 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			such as a health plan identifier (HPID) and/or national provider identifier (NPI). (Directive to Take Action)	

END