DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee A

Christine Kim, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 23 – Liberalized Remorse Period for Medicare Advantage Plan Insureds
2. Council on Medical Service Report 5 - Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
3. Council on Medical Service Report 8 - Rural Health Transformation Program Update & Workforce Challenges
4. Resolution 104 – Improving Choice, Competition, and Affordability in the ACA Marketplaces
5. Resolution 105 – Oppose Medicare Advantage Auto Enrollment
6. Resolution 109 – Insurance Coverage for Pediatric Intercranial Neuromodulation for Drug-Resistant Epilepsy
7. Resolution 112 – Ensuring Coverage and Access to Adult Strabismus Surgery

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Medical Service Report 3 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
9. Resolution 101 - Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”
10. *Resolution 103 - Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
11. Resolution 108 – Ensuring Physician Input in the Development of CMMI Models
12. *Resolution 110 – Medicaid Coverage for Incarcerated Individuals
13. Resolution 114 – Opposing Alternative Funding Programs
14. Resolution 115 – Patient Continuity Protections During Payer, PBM Changes
15. Resolution 116 – Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs

RECOMMENDED FOR ADOPTION IN LIEU OF

16. Resolution 106 – Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
    Resolution 111 – Advocating for Insurance Coverage of Scale Cooling Therapy to Prevent Chemotherapy-Induced Alopecia

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RECOMMENDED FOR REFERRAL

17. Resolution 107 – Oversight of Medicare Advantage Plan
18. *Resolution 113 – Health Insurance Coverage of Hearing Devices and Related Services
19. Resolution 118 - Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

RECOMMENDED FOR NOT ADOPTION

20. Resolution 102 – Study for EMTALA Relief in Psychiatric Facilities

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

21. Resolution 117 – Universal Out of Network Benefits

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RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 23 – LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 23 is adopted and the remainder of the report filed.

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

1) That our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services to create a comprehensive strategy to educate people approaching the age of Medicare eligibility and for annual enrollment periods about key aspects of Medicare affecting choices between traditional Medicare and Medicare Advantage (MA) plans. (Directive to Take Action)

2) That our AMA support a Medicare policy that allows beneficiaries who enroll in MA for the first time to disenroll for any reason and return to traditional Medicare within the first 12 months of enrollment in the plan. (New HOD Policy)

3) That our AMA reaffirm Policy H-330.866, "Medigap Patient Protections." (Reaffirm HOD Policy)

A majority of testimony supported the recommendations in Board of Trustees Report 23 as written. A delegation's request to refer the second recommendation was not supported in testimony. Several commenters noted that the proposed "first 12 months" remorse period seems reasonable, and an amendment to delete "for the first time" in the second resolve did not garner support. Your Reference Committee believes that amendments proffered by an individual to add new recommendations are unnecessary as they are sufficiently addressed in Policy H-330.866, which is recommended for reaffirmation. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

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(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – INCLUSION OF DISCOUNTED PRESCRIPTION MEDICATION IN PATIENT COST SHARING

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 5 is adopted and the remainder of the report filed.

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

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

Testimony on Council on Medical Service Report 5 was generally supportive of the recommendation's adoption. One delegation voiced concern related to the potential for fraud related to patient payments and the use of independent online physician prescription services, suggesting referral back to the Council. The Council responded by explaining that federal law addresses the concerns around fraud and the issue of online prescription services is altogether separate from the current report. Further, an individual proffered an amendment to encourage education around alternative funding programs and their impact, however, the Council pointed out that this is covered by current AMA policy. Aside from the aforementioned concern and amendment, the remainder of testimony was strongly in support of adoption of the recommendation as written. Therefore, your Reference Committee recommends that the recommendation in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

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(3) COUNCIL ON MEDICAL SERVICE REPORT 8 – RURAL HEALTH TRANSFORMATION PROGRAM UPDATE & WORKFORCE CHALLENGES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 8 is adopted and the remainder of the report filed.

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

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

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

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

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

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

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

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

Testimony on Council on Medical Service Report 8 was overwhelmingly supportive. Testifiers reiterated the importance of rural health care and the need to ensure that rural health systems, providers, and physicians have the support they need to succeed. Testimony also suggests directions for future Council reports on rural health including supporting practice equity, further updates on the Rural Health Transformation program, and potential options to “offset” cuts that

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many rural hospitals are experiencing. Due to the supportive testimony on this report, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

(4) RESOLUTION 104 - IMPROVING CHOICE, COMPETITION, AND AFFORDABILITY IN THE ACA MARKETPLACES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 104 be adopted.

HOD ACTION: Resolution 104 is adopted.

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

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

A majority of testimony supported Resolution 104, although two commenters testified against it. Supporters emphasized that the proposed structural reforms to the ACA would make marketplace plans more affordable and flexible, while opponents noted that the resolution would not expand access to coverage but could lead to higher premiums and increased costs to the federal government. Because supporters of Resolution 104 outnumbered opponents, your Reference Committee recommends that it be adopted.

(5) RESOLUTION 105 - OPPOSE MEDICARE ADVANTAGE AUTO ENROLLMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 105 be adopted.

HOD ACTION: Resolution 105 is adopted.

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)

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Your Reference Committee heard testimony in strong support of Resolution 105. Commenters agreed that current AMA policy (Policy H-285.905) directs the AMA to work to end auto-enrollment in Medicare Advantage but expressed a preference for the stronger language in Resolution 105. Although testimony also requested that the resolution be labeled a "Directive for Action," your Reference Committee points out that such labeling is typically not determined by reference committees but instead is assigned after the House of Delegates meeting. Your Reference Committee highlights the preference in testimony that Resolution 105 become a Directive and recommends that Resolution 105 be adopted.

(6) RESOLUTION 109 - INSURANCE COVERAGE FOR PEDIATRIC INTRACRANIAL NEUROMODULATION FOR DRUG-RESISTANT EPILEPSY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 109 be adopted.

HOD ACTION: Resolution 109 is adopted.

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

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

Testimony was strongly supportive of Resolution 109. Testimony explained that for many patients these treatments may be the only options and often significantly improve quality of life. One delegation suggested that the second resolve should be deleted as it represented a separate issue. However, the remainder of the testimony was in strong support of both resolve clauses and explained that intracranial modulation treatment is a form of non-opioid intervention for pediatric patients experiencing severe, refractory disease. Therefore, your Reference Committee recommends that Resolution 109 be adopted.

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(7) RESOLUTION 112 - ENSURING COVERAGE AND ACCESS TO ADULT STRABISMUS SURGERY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 112 be adopted.

HOD ACTION: Resolution 112 is adopted.

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

Testimony was supportive of Resolution 112 and the need for appropriate coverage of adult strabismus surgery. Testimony outlined the need for broader national insurer recognition that adult strabismus surgery is not a cosmetic procedure but is a medical necessity that can otherwise cause debilitating impairment and distress for the patient. As a result of supportive testimony, your Reference Committee recommends that Resolution 112 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(8) COUNCIL ON MEDICAL SERVICE REPORT 3 – IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 3 be amended by addition to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that the third Recommendation of Council on Medical Service Report 3 be amended by addition to read as follows:

3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.

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b. Medications are delivered to patients accurately and in a timely manner.
c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
e. Existing community pharmacies are not displaced.
f. Patients and physicians are able to opt out of telepharmacy and remote dispensing

RECOMMENDATION D:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

1. **Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs with a sufficient margin to ensure pharmacy viability.**
2. **Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including independent and/or physician-owned pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)**
3. **Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:**
    a. **Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.**
    b. **Medications are delivered to patients accurately and in a timely manner.**
    c. **Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.**
    d. **Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.**
    e. **Existing community pharmacies are not displaced.**
    f. **Patients and physicians are able to opt out of telepharmacy and remote dispensing**

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

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

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

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

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

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

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

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

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

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

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

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

Testimony on Council on Medical Service Report 3 was supportive of the report and its recommendations. While supportive, commenters did proffer a number of amendments to the recommendations in the report. First, three relatively minor amendments were proffered, which the Council accepted as friendly amendments. Second, an amendment was proffered by a delegation to Recommendation 3a that sought to clarify the wording, however the Council on Medical Service explained that the new wording could indicate support for expanded pharmacist scope of practice. Third, an individual proffered alternative third and fifth recommendations that would only allow for telepharmacy expansion in communities that do not have a community pharmacy and to prohibit pharmacy benefit managers from owning pharmacies. The Council responded to the first of these points and explained that the original wording of this recommendation protect community pharmacies while supporting patient choice. Further, in response to the second point, the Council explained that the original wording of the fourth Recommendation covers anti-competitive practices beyond only vertical integration and existing AMA Policy details advocacy to move away from vertical integration between pharmacy benefit managers and pharmacies. Finally, amendments were proffered for additional recommendations that were designed to support continuity of care for patients and support the use of long-acting injectables in outpatient pharmacies. In response to these suggested new recommendations, the Council testified that they are beyond the scope of this report and thus should not be added. Your Reference Committee wishes to note that an amendment proffered to the sixth recommendation is not possible as this recommendation is simply reaffirming existing policy. Your Reference Committee was swayed by the testimony from the Council related to the proffered amendments, the fact that amendments got no or limited support outside of the delegation or individual who proffered them, and the overwhelming testimony in support of the report. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

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(9) RESOLUTION 101 - REVISE THE USE OF LANGUAGE STIGMATIZING OBESITY IN ICD-10 CODE E66.01"MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES"

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other ~~payors~~payers to utilize ~~for~~ equivalent, ~~risk-adjusted payment for alternate~~ ICD-10-CM codes ~~with more~~ that are patient-centered, neutral, and non-stigmatizing for payment, quality measures, and risk adjustment~~language in place of ICD-10 code E66.01~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 101 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 101 be changed:

PAYER COVERAGE OF NON-STIGMATIZING LANGUAGE IN ICD-10-CM

HOD ACTION: Resolution 101 is amended with a title change.

ADOPTED LANGUAGE:

PAYER COVERAGE OF NON-STIGMATIZING LANGUAGE IN ICD-10-CM

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payers to utilize equivalent, ICD-10-CM codes that are patient-centered, neutral, and non-stigmatizing for payment, quality measures, and risk adjustment.

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

Testimony on Resolution 101 was supportive of the resolution's intent but mixed in suggested outcome. All testimony agreed that it was important for physicians to be able to use and be paid

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for codes that are non-stigmatizing to patients. Testimony from a delegation, the Council on Medical Service, and individuals supported the reaffirmation of existing AMA policy proffered by staff. However, testimony from other delegations, including the resolution's author, explained that the intent of Resolution 101 was not only code language but also payment. As a result, the Council on Medical Service proffered amended language that would allow for advocacy for all ICD-10-CM codes. Further, to ensure the title of this resolution match the amended language, the Council suggested a title change. This amendment was supported by the resolution authors and therefore, your Reference Committee recommends that Resolution 101 be adopted as amended with a title change.

(10) *RESOLUTION 103 - SUPPORTING NON-INSURANCE DIRECTED SALES OF PHARMACEUTICALS TO PATIENTS TO IMPROVE ACCESS AND REDUCE COSTS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 103 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash ~~match the lowest available bona fide patient~~ price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 103 be adopted as amended.

HOD ACTION: Resolution 103 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as

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if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel.

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel.

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

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

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

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

Testimony on Resolution 103 was generally in support of the intent, with some testimony voicing reservations. Generally, testimony outlined the importance of ensuring that patients are able to afford medications and that appropriate spending should be included in patient cost-sharing calculations. The Council on Medical Service testified that the recommendation in Council Report 5, currently before the House, has significant overlap with Resolution 103 resolve one and encouraged the removal of the first resolve, and the adoption of the recommendation in Council Report 5, to avoid duplicative policy. Two delegations voiced concern that the resolution, particularly the first resolve clause, could increase utilization management and weaken formulary protections. One of these delegations agreed with the Council on Medical Service, preferring the language in the Council's recommendation to the first resolve clause of 103. Further, in-person testimony offered an amendment of the phrasing for a portion of the second resolve designed to clarify the language. Testimony was supportive of the amendment and explained it retained the intent of the original resolution but strengthened the language.

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Your Reference Committee believes that while the language of Resolution 103 does somewhat overlap with the language in Council Report 5, the resolution is additive and complements the report language and that the amended language does strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 103 be adopted as amended.

(11) RESOLUTION 108 - ENSURING PHYSICIAN INPUT IN THE DEVELOPMENT OF CMMI MODELS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 108 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 108 be adopted as amended.

HOD ACTION: Resolution 108 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, in the development of Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation.

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)

Testimony on Resolution 108 was entirely in support of the resolution and its intent. Testifiers explained the challenges of the downstream impacts of CMMI models and how physician involvement could mitigate issues. One delegation offered an amendment intended to clarify the wording and how physicians would be nominated to participate. Although no other testimony directly addressed this amendment, your Reference Committee believes that the amendment is

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germane to the original resolution and improves its clarity. Therefore, your Reference Committee recommends that Resolution 108 be adopted as amended.

(12) *RESOLUTION 110 - MEDICAID COVERAGE FOR INCARCERATED INDIVIDUALS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 110 be amended by deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 110 be adopted as amended.

HOD ACTION: Resolution 110 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration.

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

Testimony on Resolution 110 was supportive of the intent of the resolution. All testifiers were in agreement that it is essential to ensure that incarcerated individuals have access to necessary medical care. Testimony did explain the implementation challenges that would be faced due to a provision in the Social Security Act that prohibits federal Medicaid and Medicare health spending on incarcerated individuals unless they are in an inpatient setting. To combat this, some testimony suggested reaffirmation may be more appropriate as existing policy already calls for the repeal of this prohibition and the full coverage of health care during incarceration. In-person testimony suggested that the second portion of the resolution had the potential to be interpreted offensively and therefore suggested its removal. Further, testimony explained that the removal of the second half of the resolve does not change the intent of the resolution. Since the majority of testimony was in support of the intent of this resolution and the removal of the

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second portion does not impact its implementation, your Reference Committee recommends Resolution 110 be adopted as amended.

(13) RESOLUTION 114 - OPPOSING ALTERNATIVE FUNDING PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 114 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs including but not limited to those that condition patient access to covered medications on enrollment in third-party assistance programs or reclassify covered drugs as non-essential health benefits to avoid plan payment and be it further; ~~and advocate for federal and state legislation and regulation prohibiting their use~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 114 be amended by addition of a new resolve to read as follows:

RESOLVED, that our AMA advocate for federal and state legislation or regulation prohibiting insurance benefit designs that condition patient access to a covered medication on enrollment in a third-party assistance program or that reclassify a covered prescription drug as a non-essential health benefit to avoid plan payment obligations. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 114 be adopted as amended.

HOD ACTION: Resolution 114 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs including but not limited to those that condition patient access to covered medications on enrollment in

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third-party assistance programs or reclassify covered drugs as non-essential health benefits to avoid plan payment and be it further;

RESOLVED, that our AMA advocate for federal and state legislation or regulation prohibiting insurance benefit designs that condition patient access to a covered medication on enrollment in a third-party assistance program or that reclassify a covered prescription drug as a non-essential health benefit to avoid plan payment obligations.

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

Testimony on Resolution 114 was supportive of the intent of the resolution. Testimony explained the harm that is caused by alternative funding programs and the lack of transparency in the practice. One delegation offered an amendment to generalize the language, however one of the resolution co-sponsors explained that the language was intentionally specific to ensure that alternative funding programs would not be able to be easily modified to fall outside of regulation. The resolution co-sponsors offered an alternative amendment that captured both the intent of the original resolution and the amendment to generalize language. Your Reference Committee agrees that the amendment proffered by the resolution co-sponsors is best representative of testimony and therefore recommends that Resolution 114 be adopted as amended.

(14) RESOLUTION 115 - PATIENT CONTINUITY PROTECTIONS DURING PAYER, PBM CHANGES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 115 be amended by addition to read as follows:

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 115 be amended by addition and deletion to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 115 be adopted as amended.

HOD ACTION: Resolution 115 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner; and be it further

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

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

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

Testimony on Resolution 115 was strongly in support. Testimony explained the importance of ensuring that patients have a reasonable amount of time to, in conjunction with their physician(s), develop and implement an alternative treatment plan when their health plan/pharmacy benefit manager undergoes structural changes. Amendments were proffered to ensure that the second resolve is able to stand independently and to remove specificity of the

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90-day continuity period. While the editorial change to the second resolve was accepted by the resolution authors, the removal of the 90-day continuity period was refuted as testimony felt this specificity was crucial. Further, amendments were proffered to ensure that utilization management is not increased during the transition period, patients are notified of changes, and that in-network coverage is maintained for different practice settings and physician/provider. While the original amendments were proffered as three new resolve clauses, your Reference Committee believes that the presented amended language encompasses the intent of the amendment in a more efficient manner. Since the majority of testimony was in support of this resolution and the intent of the amendments, your Reference Committee recommends that Resolution 115 be adopted as amended.

(15) RESOLUTION 116 - STUDY OF COST IMPLICATIONS OF MEDICAID MANAGED CARE ORGANIZATIONS COMPARED WITH STATE-ADMINISTERED MEDICAID PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 116 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study and report back to the HOD at ~~I-26~~ A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 116 be adopted as amended.

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HOD ACTION: Resolution 116 is amended.

ADOPTED LANGUAGE:

RESOLVED, That our American Medical Association study and report back to the HOD at A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- **The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.**
- **Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.**
- **The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration.**
- **Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity.**
- **Whether Medicaid managed care impacts patient access to care, including in rural areas.**

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

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

Testimony was supportive of Resolution 116. Three amendments were proffered, including a request to change the due date from the 2026 Interim Meeting to the 2027 Annual Meeting. Your Reference Committee recommends this change, along with new bullet points that commenters suggested be addressed in the requested study. Your Reference Committee recommends that Resolution 116 be adopted as amended.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(16) RESOLUTION 106 - INSURANCE COVERAGE FOR SCALP COOLING (COLD CAPPING) THERAPY
RESOLUTION 111 - ADVOCATING FOR INSURANCE COVERAGE OF SCALP COOLING THERAPY TO PREVENT CHEMOTHERAPY-INDUCED ALOPECIA

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 106 be adopted in lieu of Resolutions 106 and 111.

RESOLVED, that our American Medical Association encourage insurance coverage, and reduced cost-sharing, for scalp cooling therapy for patients undergoing chemotherapy regimens for which scalp cooling is supported by evidence-based clinical guidelines to prevent chemotherapy-induced alopecia; and be it further

RESOLVED, that our AMA work with interested national medical specialty societies to support the development of clinical guidance on appropriate patient selection criteria for scalp cooling therapy, promote broad and equitable access to scalp cooling therapy, advance public awareness and legislative advocacy supporting insurance coverage of scalp cooling, and encourage research into additional evidence-based interventions for chemotherapy-induced alopecia. (New HOD Policy)

HOD ACTION: Alternate Resolution 106 is adopted in lieu of Resolutions 106 and 111.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association encourage insurance coverage, and reduced cost-sharing, for scalp cooling therapy for patients undergoing chemotherapy regimens for which scalp cooling is supported by evidence-based clinical guidelines to prevent chemotherapy-induced alopecia; and be it further

RESOLVED, that our AMA work with interested national medical specialty societies to support the development of clinical guidance on appropriate patient selection criteria for scalp cooling therapy, promote broad and equitable access to scalp cooling therapy, advance public awareness and legislative advocacy supporting insurance coverage of scalp cooling, and encourage research into additional evidence-based interventions for chemotherapy-induced alopecia. (New HOD Policy)

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RESOLUTION 106

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

RESOLUTION 111

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

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

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

Testimony on Resolutions 106 and 111 was mixed. Although commenters agreed that the resolutions should be combined and considered together, testimony did not coalesce around a particular disposition. Supporters of Resolutions 106 and 111 noted that alopecia is a serious consequence of chemotherapy and, furthermore, that scalp cooling systems are FDA-approved, supported by strong safety and efficacy data, and endorsed by reputable national organizations. However, a commenter proffering alternate language cautioned that available evidence supports the efficacy of scalp cooling for many chemotherapy regimens but it is contraindicated for certain patients. One delegation argued that coverage of scalp cooling will crowd out coverage of more important services and further increase the cost of insurance. This same delegation requested referral. Based upon the range of opinions and alternate language offered in testimony, your Reference Committee crafted an alternate resolution that encourages insurance coverage of scalp cooling without calling for a new mandate, and maintains that coverage should be supported by evidence-based clinical guidelines. Your Reference Committee recommends that Alternate Resolution 106 be adopted in lieu of Resolutions 106 and 111.

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RECOMMENDED FOR REFERRAL

(17) RESOLUTION 107 – OVERSIGHT OF MEDICARE ADVANTAGE PLAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 107 be referred.

HOD ACTION: Resolution 107 is referred.

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)

Testimony on Resolution 107 was mixed. Testimony noted that the first three resolve clauses are addressed in existing AMA policy (Policies D-285.959 and H-330.867), with some testimony also noting that the first two resolves are unnecessary and should be deleted. Testimony on the fourth and fifth resolve clauses was mixed, with some commenters supporting, and others cautioning against MedPAC's recommended approach to risk adjustment in Medicare Advantage. Several amendments were proffered to the various resolve clauses, and referral was also suggested. Your Reference Committee agrees that the resolution is complex and warrants further study before new policy is adopted on a preferred risk adjustment approach. We therefore recommend that Resolution 107 be referred.

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(18) *RESOLUTION 113 - HEALTH INSURANCE COVERAGE OF HEARING DEVICES AND RELATED SERVICES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 113 be referred.

HOD ACTION: Resolution 113 is referred.

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

Testimony on Resolution 113 was mixed. Supporters highlighted the need to close a gap in AMA policy with regard to hearing coverage for adults aged 18-64. Some spoke in favor of covering all individuals regardless of age. Cost concerns were raised, especially due to budget neutrality requirements in Medicare. Additionally, your Reference Committee recognizes that the coverage landscape is complex and has concerns about unintended consequences on state Medicaid budgets which could affect other physician services. Several speakers, including practicing physicians who provide hearing services, requested referral of the resolution so that scope of practice issues could be addressed with assurances that hearing services must be provided by appropriate physician-led teams. Your Reference Committee agrees that these issues are complex and recommends that Resolution 113 be referred.

(19) RESOLUTION 118 – ADDRESSING PROPOSALS TO IMPLEMENT INTERNATIONAL REFERENCE PRICING FOR PHYSICIAN-ADMINISTERED DRUGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 is referred.

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

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

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

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1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

a. The arbitration process should be overseen by objective, independent entities.

b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.

c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.

d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.

e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.

f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.

g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.

h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.

i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.

b. The use of any international drug price index or average should preserve patient access to necessary medications.

c. The use of any international drug price index or average should limit burdens on physician practices by:

1. Ensuring reimbursement at or above acquisition cost for physician-administered drugs.

2. Protecting patient access to in-office treatments.

3. Avoiding shifting care to higher-cost settings.

4. Minimizing administrative and financial burdens on physician practices.

d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (Modify Current HOD Policy)

Testimony on Resolution 118 was focused on the need for further study in order to understand the issue presented. Testimony explained concerns that the resolution may impact practice sustainability, drug supply chains, and could block drug innovation. Further, testimony voiced concern that the language of the resolution may be too prescriptive and block effective avenues for advocacy. The resolution's authors responded to these pieces of testimony explaining that the resolution only seeks to clarify existing AMA policy without changing the organization's position. In-person testimony was mixed on this issue, with some testimony explaining the importance of this issue being addressed in a timely fashion. Testimony in support of the resolution explained potential issues with international reference pricing impacting physician

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practices and patients access. However, other delegations and the Council on Medical Service supported referral and reiterated how complex the issue is. In order to minimize the potential for unintended consequences, this testimony suggested that the item be studied further and a report presented to the House. Your Reference Committee agrees with the testimony encouraging study of this report due to its complexity and therefore recommends that Resolution 118 be referred.

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RECOMMENDED FOR NOT ADOPTION

(20) RESOLUTION 102 - STUDY FOR EMTALA RELIEF IN PSYCHIATRIC FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 102 be not adopted.

HOD ACTION: Resolution 102 is not adopted.

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

Testimony on Resolution 102 was mixed. The resolution was supported by the authors and some other delegations with testimony explaining the importance of assessing the potential appropriateness for a study on psychiatric Emergency Medical Treatment & Labor Act (EMTALA) relief. However, a number of other delegations voiced strong opposition to the report explaining that this could have a serious weakening impact on EMTALA and did not believe that the study was warranted nor appropriate. Since the quorum of testimony centered on opposing this resolution, your Reference Committee recommends that Resolution 102 be not adopted.

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(21) RESOLUTION 117 - UNIVERSAL OUT OF NETWORK BENEFITS

RECOMMENDATION:

Your Reference Committee recommends that AMA Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 be reaffirmed in lieu of Resolution 117.

HOD ACTION: Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 reaffirmed in lieu of Resolution 117.

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)

Testimony on Resolution 117 was mixed. Some commenters noted that Resolution 117 is addressed by existing AMA policies that support requirements that insurers offer plans that include out-of-network benefits. Concerns about the resolution were also expressed regarding its feasibility, enforceability, and inconsistency with the existing coverage landscape that includes Health Maintenance Organizations (HMOs), which by definition have closed networks. A commenter noted that adopting the resolution as written would suggest that the AMA believes HMOs should no longer exist, which would be inconsistent with AMA policy on patient choice of insurance. This commenter also noted that this exact resolution was just considered by the House of Delegates at the 2025 Interim Meeting. An individual proposed the addition of new policy opposing 1) narrow networks and 2) unreasonable financial barriers to medically necessary out-of-network care. However, your Reference Committee points out that existing policy opposes narrow networks (Policies H-450.941 and H-285.901), and Policies H-285.904 and H-285.908 already state that patients must not be financially penalized for receiving out-of-network care. Accordingly, your Reference committee recommends that Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 be reaffirmed in lieu of Resolution 117.

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:

a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

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

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

Patient Access to Covered Benefits Ordered by Out-of-Network Physicians D-285.958
1. Our American Medical Association will develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory

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testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability.
2. Our AMA will collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

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

Health System Reform Legislation H-165.838
…5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

Physician Penalties for Out-of-Network Services H-180.952
Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.

Managed Care Organization Reimbursement Formulas D-165.989
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.

Network Adequacy H-285.908
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.

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3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite

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standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

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This concludes the report of Reference Committee A. I would like to thank Landon Combs, MD, Nancy Fan, MD, Tra'Chella Johnson Foy, MD, Jerry Halverson, MD, Joanne Loethen, MD, MA, and Maximiliam Pany, MD, PhD.

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DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee B

Jennifer Hone, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 08 - Council on Legislation Sunset Review of 2016 House Policies
2. Board of Trustees Report 12 - The Uniform Health-Care Decisions Act
3. Board of Trustees Report 13 - Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes
4. Board of Trustees Report 21 - Abolishing Venue Shopping
5. Board of Trustees Report 25 - Federal Legislation to Prohibit the Corporate Practice of Medicine
6. Board of Trustees Report 27 - Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
7. Resolution 209 - Protecting Mental Health Treatment Privacy in Legal Proceedings
8. Resolution 213 - Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
9. Resolution 218 - Opposing the Practice of Jury Anchoring in Medical Liability Cases
10. Resolution 228 - Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
11. Resolution 235 - Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
12. Resolution 237 - Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan

RECOMMENDED FOR ADOPTION AS AMENDED

13. Board of Trustees Report 14 - Binding Arbitration in Health Insurance Contracts
14. Board of Trustees Report 15 - Protecting the Prescriptive Authority of Plenary Licensed Physicians
15. Board of Trustees Report 19 - Root Cause Analysis of the Causes of the Decline of Private Medical Practice
16. Board of Trustees Report 24 - AMA Advocacy to Mitigate Medicaid Cuts
17. Board of Trustees Report 28 - Accountability in the Use of Augmented Intelligence for Prior Authorization

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18. Resolution 203 - Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
19. Resolution 207 - Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
20. Resolution 208 - Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
21. Resolution 212 - Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
22. Resolution 216 - Protecting Healthcare as a Sensitive Location
23. Resolution 219 - Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
24. Resolution 229 - Physicians are not Providers
25. Resolution 232 - Banning Flavored Cannabis E-Cigarettes
26. Resolution 239 - Medicare Administrative Contractor Policy Modification
27. Resolution 240 - Ending Private Equity Dividend Recapitalization in Healthcare
28. Resolution 243 - Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
29. Resolution 244 - Eliminate Administrative Barriers to Appeal Wrongful Denials
30. Resolution 247 - Comprehensive ERISA Reform
31. Resolution 248 - Medical Staff Oversight of Hospital Augmented Intelligence
32. Resolution 250 - Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities
33. Resolution 252 - Immediate Action to Prevent Further Immigrant Deaths
34. Resolution 254 - OMB Proposed Rule: Regulation for Federal Financial Assistance

RECOMMENDED FOR ADOPTION IN LIEU OF

35. Resolution 201 - Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
    Resolution 233 - Banning Synthesized, Purified or Derivative Products from Kratom
36. Resolution 222 - Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
37. Resolution 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
    Resolution 230 - Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
38. Resolution 238 - Prohibiting the Independent Practice of Medicine by Artificial Intelligence
    Resolution 246 - Artificial Intelligence Scope of Practice
    Resolution 249 - Bringing Physicians' Voices to the Implementation of AI Prescribers
39. Resolution 251 - Minimum Standards for Public Health Leaders
40. Resolution 253 - Protection of Medicaid Beneficiaries from Politically Motivated and Procedurally Deficient Federal Funding Deferrals

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RECOMMENDED FOR REFERRAL

41. Resolution 202 - Using and Defining “Unsupervised Practice of Medicine”
42. Resolution 206 - Overall Hospital Quality Star Ratings / CMS Star Ratings
43. Resolution 221 - Universal Newborn Congenital Cytomegalovirus Screening
44. Resolution 223 - Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
45. Resolution 225 - Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
46. Resolution 236 - Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
47. Resolution 241 - Strengthening Our AMA Efforts Toward CPOM Prohibition
48. Resolution 242 - Reducing Emergency Department Boarding through Payment Reform

RECOMMENDED FOR NOT ADOPTION

49. Resolution 245 - State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

50. Resolution 204 - D-400.982 Revision
51. Resolution 205 - Repeal of the Merit-Based Incentive Payment System (MIPS)
52. Resolution 210 - Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
53. Resolution 211 - Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
54. Resolution 214 - Medical Student Loans Should Not Be Capped
55. Resolution 215 - Oppose Medicare Efficiency Adjustments
56. Resolution 217 - Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
57. Resolution 220 - Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians
58. Resolution 224 - Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
59. Resolution 227 - Standby Capacity Payments and Health IT for Hospitals in Rural Areas
60. Resolution 231 - Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
61. Resolution 234 - Physician Unity in Advocacy Regarding Physician Reimbursement

RECOMMENDED FOR FILING

62. Board of Trustees Report 37 – AMA Policies on Gender Affirming Care

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RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 08 - COUNCIL ON LEGISLATION SUNSET REVIEW OF 2016 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 08 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 08 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979

1. **Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians (MD,DO, or Foreign equivalent) by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented.**
2. **Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led (MD,DO, or Foreign equivalent) health care teams or to mandate that the VA adopt policy regarding the same.**
3. **Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and other non-physicians (non-MD,DO, or Foreign equivalent) in unsupervised practice.**
4. **Our AMA will collaborate with other medical professional organizations to vigorously oppose the VA expanding the role of APRNs and other non-physicians (non- MD,DO, or Foreign equivalent) within the VA in unsupervised practice.**

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

Your Reference Committee heard testimony that was largely supportive of adopting the recommendations of Board of Trustees Report 08 regarding which AMA policies to retain and which to sunset. Although some commenters raise concerns with different actions recommended by the report, there is a clear consensus in favor of adopting the recommendations. It was noted that amendments should be made to D-35.979, but there

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was minimal testimony provided on this point. Therefore, your Reference Committee recommends that Board of Trustees Report 08 be adopted, and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 12 - THE UNIFORM HEALTH-CARE DECISIONS ACT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 12 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 12 is adopted, and the remainder of the Report filed.

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

1. That Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," be reaffirmed. (Reaffirm HOD Policy)
2. That Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," be reaffirmed. (Reaffirm HOD Policy)
3. That Policy H-85.956, "Educating Physicians About Advance Care Planning," be reaffirmed. (Reaffirm HOD Policy)
4. That Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," be reaffirmed. (Reaffirm HOD Policy)
5. That Policy H-140.826, "Use of Psychiatric Advance Directives," be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard limited but unanimous testimony in favor of adopting the recommendations of Board of Trustees Report 12. Commenters agreed with the Board of Trustees' assessment that it is not appropriate for our AMA to endorse the Uniform Health-Care Decisions Act (UHCDA) at this time given the conflict between the UHCDA and existing AMA policy and clinical practices. Instead, Board of Trustees Report 12 recommends reaffirmation of AMA policies relating to advance directives. Your Reference Committee agrees with the conclusions of the report and its recommendations. Therefore, your Reference Committee recommends that Board of Trustees Report 12 be adopted, and the remainder of the report be filed.

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(3) BOARD OF TRUSTEES REPORT 13 - REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAL PURPOSES

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 13 is adopted, and the remainder of the Report filed.

The Board of Trustees recommends the following be adopted and the remainder of the report be filed.

1. That the referred clause from Resolution 209-A-25, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," not be adopted.
2. That our American Medical Association advocate to the U.S. Department of Justice to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a legitimate medical purpose. (Directive to Take Action)
3. That our AMA advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care. (Directive to Take Action)
4. That our AMA support the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when patients lose access to care due to a law enforcement or other action that results in the closure of a physician's practice. (New AMA Policy)

Your Reference Committee reviewed the testimony for Board of Trustees Report 13. The testimony was strongly in favor of adoption. Your Reference Committee agrees that physicians should control who and what defines a "legitimate medical purpose," and while medical boards may be subject to state legislative actions in some cases, medical boards also are comprised almost entirely of physicians, one of the many reasons our AMA supports licensure at the state level. Your Reference Committee also notes that our AMA may choose to use any AMA policy to support legal action on behalf of physicians. For these reasons, your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the report be filed.

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(4) BOARD OF TRUSTEES REPORT 21 - ABOLISHING VENUE SHOPPING

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 21 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 21 is adopted, and the remainder of the Report filed.

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

1) That our American Medical Association amend Policy D-438.968, "Abolishing Venue Shopping" by deletion of clause 2 as it has been accomplished by this report:

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

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

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

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

Your Reference Committee heard strong support for the recommendations made in Board of Trustees Report 21, which would amend existing AMA policy to provide that our AMA will work with interested medical society partners to combat venue shopping in medical liability lawsuits. Commenters emphasize the harms of venue shopping, where attorneys seek out the most plaintiff-friendly jurisdiction in which to bring medical liability lawsuits, regardless of whether such jurisdiction is the most reasonable location in which to bring the suit, and urge our AMA to continue vigorous advocacy efforts to curb this practice. Your Reference Committee agrees, and therefore recommends Board of Trustees Report 21 be adopted and the remainder of the report be filed.

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(5) BOARD OF TRUSTEES REPORT 25 - FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 25 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 25 is adopted and the remainder of the Report filed.

BOARD OF TRUSTEES REPORT 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)
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.

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

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

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

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

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

8.~~9.~~ Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify Current HOD Policy)

Your Reference Committee heard testimony establishing that Board of Trustees Report 25 and Resolution 241 serve complementary but distinct purposes and accordingly considered them separately. Testimony regarding Board of Trustees Report 25 was overwhelmingly supportive. As such, your Reference Committee recommends that the recommendations contained in Board of Trustees Report 25 be adopted and the remainder of the report be filed.

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(6) BOARD OF TRUSTEES REPORT 27 - UPDATE THE STATUS OF VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK OF ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS BY CMS

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 27 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 27 is adopted, and the remainder of the Report filed.

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 20267 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Update HOD Policy)

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

Your Reference Committee heard extensive testimony on Board of Trustees Report 27, with the majority consensus favoring adoption of the report's call for robust, ongoing action to address the financial burdens imposed on physician practices by virtual credit card (VCC) payment and fee-based electronic funds transfer (EFT) fees. Many commenters spoke to the harms these fees inflict on physician practices and the importance of continued advocacy by our AMA. Your Reference Committee agrees that the actions called for by the report—stronger CMS enforcement, clear regulatory action, and federal legislation (such as the No Fees for EFTs Act)—are needed. Therefore, your Reference Committee recommends that the Board of Trustees Report 27 be adopted, and the remainder of the report be filed.

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(7) RESOLUTION 209 - PROTECTING MENTAL HEALTH TREATMENT PRIVACY IN LEGAL PROCEEDINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 209 be adopted.

HOD ACTION: Resolution 209 is referred.

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

Your Reference Committee heard strong support for Resolution 209. Your Reference Committee appreciates the concern raised that the resolution could be interpreted as "overly broad." Your Reference Committee counsels that state and federal laws, as well as the courts, already balance privacy protections of medical information in numerous contexts, including medical records. Your Reference Committee does not agree that the resolution is overly broad because calling for "protections" is not viewed as an absolute bar given that the Health Insurance Portability and Accountability Act, 42 CFR Part 2, and the courts already provide for limited discovery, and balance in when such records may be disclosed. These balancing acts also are reflected throughout AMA policy, including H-315.983 and Ethics Policy 3.2.1. For these reasons, your Reference Committee recommends that Resolution 209 be adopted.

(8) RESOLUTION 213 - PROHIBITING PHARMACY BENEFIT MANAGERS FROM OWNING PHARMACIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 213 be adopted.

HOD ACTION: Resolution 213 is adopted.

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)

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Your Reference Committee heard strong support for adoption of Resolution 213, which calls for our AMA to develop model state legislation to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies. Commenters noted that oversight of PBMs and vertical integration of PBMs and pharmacies is appropriate, needed, and in alignment with AMA policies. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 213 be adopted.

(9) RESOLUTION 218 - OPPOSING THE PRACTICE OF JURY ANCHORING IN MEDICAL LIABILITY CASES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 218 be adopted.

HOD ACTION: Resolution 218 is adopted.

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

Your Reference Committee received supportive testimony for Resolution 218. Commenters noted that while our AMA has done extensive work on medical liability reform, AMA policy does not include opposition to jury anchoring, a practice in which plaintiffs' attorneys attempt to bias juries by placing a specific, inflated dollar value on damages early in the trial process. Some commenters suggested replacing the term "jury anchoring" with "financial anchoring" or "damages anchoring" to make the resolution clearer. However, the term "jury anchoring" is a term of art that is understood to refer to a common practice in medical liability cases. Therefore, your Reference Committee recommends that Resolution 218 be adopted.

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(10) RESOLUTION 228 - DEPARTMENT OF DEFENSE HEALTH CARE INVESTMENT AT MILITARY BASES IN MATERNITY CARE HEALTH PROFESSIONAL SHORTAGE AREAS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 228 be adopted.

HOD ACTION: Resolution 228 is adopted.

RESOLVED, that our American Medical Association urge the Department of Defense to provide comprehensive reproductive health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to comprehensive reproductive care and maternal care in rural areas and reduced maternal mortality rates. (Directive to Take Action)

Your Reference Committee heard broad, unanimous support for Resolution 228. Commenters spoke to the importance of ensuring access to reproductive and maternal health care for military and non-military personnel working on military bases and note that the resolution aligns with our AMA's ongoing work in the maternal health care space. Your Reference Committee agrees. Though an amendment was provided that would have limited this policy to only those individuals that are eligible for TRICARE, your Reference Committee notes that this was not the intention of the resolution, nor was it in alignment with the majority of the testimony. Therefore, your Reference Committee recommends that resolution 228 be adopted.

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(11) RESOLUTION 235 - ESTABLISHING HEALTHCARE MONITORING AND ACCOUNTABILITY IN IMMIGRATION DETENTION FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 is adopted.

RESOLVED, that our American Medical Association support independent, transparent, unannounced inspections of all ICE detention facilities, with anti-retaliation protections for detainees and health staff who participate (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to reform ICE's waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity. (New HOD Policy)

Your Reference Committee received supportive testimony for Resolution 235. Testimony highlighted the importance of accountability, independent inspections, revised waiver policies, and protecting patient safety and human rights in immigration detention. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

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(12) RESOLUTION 237 - GUARANTEED 30-DAY TRANSITION FILL OF CURRENTLY PRESCRIBED INSULIN AT THE BEGINNING OF EACH YEAR PLAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 237 be adopted.

HOD ACTION: Resolution 237 be adopted.

RESOLVED, that our American Medical Association adopt as policy and advocate that beneficiaries of ERISA-governed health plans be allowed a 30-day transition fill of insulin at the beginning of each plan year to allow time for the formulary preference to be determined by the patient and prescriber. (Directive to Take Action)

Your Reference Committee received minimal but supportive testimony for Resolution 237. Testimony noted that this policy would address dangerous insulin therapy interruptions, especially during insurance coverage or formulary changes, and support continuity of care. Given the unanimously supportive testimony, your Reference Committee recommends that Resolution 237 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(13) BOARD OF TRUSTEES REPORT 14 - BINDING ARBITRATION IN HEALTH INSURANCE CONTRACTS

RECOMMENDATION A:

Your Reference Committee recommends that the second recommendation of Board of Trustees Report 14 be amended by addition to read as follows:

That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts that include but are not limited to clear timelines, enforcement mechanisms, reasonable limits on arbitration costs, neutral arbitrator selection, and safeguards against venue manipulation; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 14 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

1. **That our American Medical Association Policy D-435.967, "Binding Arbitration in Health Insurance Contracts," be rescinded having been accomplished by this report. (Rescind HOD Policy)**

2. **That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians**

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can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts that include but are not limited to clear timelines, enforcement mechanisms, reasonable limits on arbitration costs, neutral arbitrator selection, and safeguards against venue manipulation; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes. (New HOD Policy)

3. **That our AMA (1) opposes requiring mandatory binding arbitration as a condition of participation in an insurance company's provider network; (2) supports a physician's right to choose between arbitration and the public court system after a dispute arises, rather than being forced to waive their right to a jury trial; (3) believes that no physician should be required to participate in an arbitration or mediation process that is not the result of meaningful mutual agreement between the physician and health insurer; (4) advocates that all arbitration awards involving physician-payer disputes be reported to a centralized de-identified database to ensure transparency and to identify patterns of frequent bad-faith claims settlement practices by insurers. (New HOD Policy)**

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

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

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ensure transparency and to identify patterns of frequent bad-faith claims settlement practices by insurers. (New HOD Policy)

Your Reference Committee notes that the testimony for Board of Trustees Report 14 was generally in favor of adoption, with some commenters suggesting amendments. Wide support was heard for the development of resources to help physicians navigate the pitfalls of arbitration agreements and negotiate those agreements where possible. A friendly amendment was offered that would ensure that the materials to be developed include timelines and enforcement considerations. This amendment received support from other commenters.

Your Reference Committee agrees that our AMA should provide guidance to physicians facing arbitration proceedings in health insurance contracts and further agrees that including timelines and enforcement considerations in this guidance would be beneficial. Therefore, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and that the remainder of the report be filed.

(14) BOARD OF TRUSTEES REPORT 15 - PROTECTING THE PRESCRIPTIVE AUTHORITY OF PLENARY LICENSED PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that recommendation 1 of Board of Trustees Report 15 be amended by addition to read as follows:

That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas, with report back at A-27. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that recommendation 2 of Board of Trustees Report 15 be amended by addition and deletion to read as follows:

That our AMA work with ~~urge~~ pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).

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RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 15 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 15 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

1. **That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas, with report back at A-27. (Directive to Take Action)**

2. **That our AMA work with pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).**

3. **That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed. (Reaffirm HOD Policy)**

4. **That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows: Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.**
   Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

   1. **Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.**
   2. **Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.**
   3. **Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.**

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4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care. (Modify Current HOD Policy)

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

1. That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas. (Directive to Take Action)
2. That our AMA urge pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).
3. That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed. (Reaffirm HOD Policy)
4. That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows:

1. ~~Our American Medical Association will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.~~
   Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

~~3.~~2. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

~~4.~~3. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.

~~5.~~4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care. (Modify Current HOD Policy)

Your Reference Committee received mostly supportive testimony for Board of Trustees Report 15. Some minor amendments were offered that received additional supportive testimony including a proposed amendment seeking a report back to the House of Delegates and a proposal to work with pharmacies to develop a reporting framework on

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refusals to fill. Therefore, your Reference Committee recommends that of Board of Trustees Report 15 be adopted as amended and that the remainder of the report be filed.

(15) BOARD OF TRUSTEES REPORT 19 - ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 19 be amended by addition and deletion to read as follows:

That consistent with Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical Practice" ~~be~~ our AMA further study and report back on the role of physician non-compete agreements and other physician employment restrictions as potential contributors to the decline of private medical practice, including their impact on physician mobility, the ability of physicians to establish or re-establish independent practices, patient access and continuity of care, and the maintenance of market power by dominant health systems ~~rescinded as being accomplished by this report~~. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Board of Trustees Report 19 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 19 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

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";**

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e. **H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service";**
f. **D-240.994, "Payment Variations Across Outpatient Sites of Service"; D-330.997, "Appropriate Payment Level Differences by Place and Type of Service";**
g. **D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule";**
h. **H-385.921, "Health Care Access for Medicaid Patients";**
i. **D-160.907, "Health System Consolidation";**
j. **D-215.984, "Health System Consolidation";**
k. **H-180.947, "Maintaining Freedom of Choice with Insurance Products";**
l. **D-160.906, "Strengthening Efforts Against Horizontal & Vertical Consolidation";**
m. **D-160.908, "Vertical Consolidation in Health Care – Markets or Monopolies";**
n. **D-385.940, "Stark Law Self-Referral Ban";**
o. **H-215.960, "Hospital Consolidation";**
p. **H-215.969, "Hospital Merger Study";**
q. **D-225.995, "Hospital Merger Study";**
r. **H-383.988, "Physicians' Ability to Negotiate and Undergo Practice Consolidation";**
s. **H-160.885, "Impact of Integration and Consolidation on Patients and Physicians";**
t. **H-160.960, "Corporate Ownership of Established Private Medical Practices";**
u. **D-405.988, "The Preservation of the Private Practice of Medicine";**
v. **D-160.909, "Advocacy of Private Practice Options for Healthcare Operations in Large Corporations";**
w. **D-330.909, "Study the Costs of Administrative and Regulatory Burdens";**
x. **H-110.985, "340B Drug Discount Program"; and**
y. **H-155.976, "Administrative Costs and Access to Health Care" (Reaffirm HOD Policy)**

2. **Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy)**
3. **That consistent with Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical Practice" our AMA further study and report back on the role of physician non-compete agreements and other physician employment restrictions as potential contributors to the decline of private medical practice, including their impact on physician mobility, the ability of physicians to establish or re-establish independent practices, patient access and continuity of care, and the maintenance of market power by dominant health systems. (Modify HOD Policy)**

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

1. That our AMA reaffirm the following policies:

a. H-330.932, “Cuts in Medicare and Medicaid Reimbursement”;
b. H-400.957, “Medicare Reimbursement of Office-Based Procedures”;
c. H-390.879, “Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service”;
d. D-330.902, “The Site-of-Service Differential”;
e. H-240.958, “Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service”;
f. D-240.994, “Payment Variations Across Outpatient Sites of Service”; D-330.997, “Appropriate Payment Level Differences by Place and Type of Service”;
g. D-400.990, “Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule”;
h. H-385.921, “Health Care Access for Medicaid Patients”;
i. D-160.907, “Health System Consolidation”;
j. D-215.984, “Health System Consolidation”;
k. H-180.947, “Maintaining Freedom of Choice with Insurance Products”;
l. D-160.906, “Strengthening Efforts Against Horizontal & Vertical Consolidation”;
m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”;
n. D-385.940, “Stark Law Self-Referral Ban”;
o. H-215.960, “Hospital Consolidation”;
p. H-215.969, “Hospital Merger Study”;
q. D-225.995, “Hospital Merger Study”;
r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”;
s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”;
t. H-160.960, “Corporate Ownership of Established Private Medical Practices”;
u. D-405.988, “The Preservation of the Private Practice of Medicine”;
v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”;
w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”;
x. H-110.985, "340B Drug Discount Program"; and
y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy)

2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy)

3. That Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice” be rescinded as being accomplished by this report. (Rescind HOD Policy)

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Your Reference Committee received limited and mixed testimony for Board of Trustees Report 19. However, weighty testimony was provided in support of Board of Trustees Report 19. Multiple commenters supported adopting the report's recommendation to reaffirm existing AMA policies that remain relevant and aligned with the concerns raised in the original resolution that prompted the report, particularly regarding the preservation of physician autonomy, reduction of unnecessary administrative burden, and support for independent practice sustainability. Reaffirming existing policy recognizes the continued importance of these positions while maintaining consistency with our AMA's longstanding advocacy efforts in this area. In addition to this, testimony was heard, and amendments were provided, that supported retaining D-405.965 for one additional year so that our AMA can continue to study the role of physician non-compete agreements. Testimony favored providing this additional information and noted that, though it was positive to reaffirm policy, it should also be supported by continued action. Therefore, your Reference Committee recommends that the Board of Trustees Report 19 be adopted as amended, and the remainder of the report be filed.

(16) BOARD OF TRUSTEES REPORT 24 - AMA ADVOCACY TO MITIGATE MEDICAID CUTS

RECOMMENDATION A:

Your Reference Committee recommends that the first sentence of the recommendation made by Board of Trustees Report 24 be amended by addition and deletion to read as follows:

The Board of Trustees recommends that the fourth item of Policy D-290.970, "Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts," be amended by striking "A-26" and inserting "A-27"~~a rescinded as having been accomplished by this report~~ and that the remainder of the report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 24 be amended by addition of the following new recommendation to read as follows:

The Board of Trustees recommends that existing AMA policies "Preservation of Medicaid" (H-290.951), "Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts" (D-290.970), "Opposition to Medicaid Work Requirements" (H-290.961), and "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding" (H-285.898) be reaffirmed.

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RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 24 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

The Board of Trustees recommends that the fourth item of Policy D-290.970, "Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts," be amended by striking "A-26" and inserting "A-27" and that the remainder of the report be filed.

1. **Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025");**
2. **Through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid;**
3. **Continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21;**

The Board of Trustees recommends that existing AMA policies "Preservation of Medicaid" (H-290.951), "Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts" (D-290.970), "Opposition to Medicaid Work Requirements" (H-290.961), and "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding" (H-285.898) be reaffirmed.

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

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

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Your Reference Committee heard broad support for Board of Trustees Report 24 and AMA's advocacy to mitigate Medicaid cuts enacted by Public Law 119-21. Commenters endorsed strong, ongoing advocacy and requested continued updates from the Board of Trustees to the House of Delegates. An amendment was offered to require the Board of Trustees to report back at the 2027 Annual Meeting of the House of Delegates to allow the House to assess our AMA's progress on Medicaid advocacy as more significant cuts made by Public Law 119-21 begin to take effect. This amendment received support, including from the Board of Trustees.

An amendment was offered to further elevate mitigation of Medicaid cuts made by Public Law 119-21 (also known as the "One Big Beautiful Bill Act"), including delaying work requirements and establishing an appropriate definition of medical frailty, as a top advocacy priority. Your Reference Committee appreciates that the cuts made by P.L. 119-21 are a pressing issue, and that advocacy to reverse or mitigate these cuts is urgently needed. However, the cuts in P.L. 119-21 are already addressed through existing AMA policies in conjunction with Resolution 243, which relates to the medical frailty exemption and which your Reference Committee is recommending be adopted as amended. Existing policy already establishes preserving Medicaid as a "top legislative advocacy priority" of our AMA, opposes work requirements as a condition of Medicaid eligibility, supports the use of state provider and managed care organization taxes to finance Medicaid, and specifically directs our AMA to advocate to reverse or mitigate P.L. 119-21's cuts. Furthermore, our AMA is actively and aggressively carrying out these policies through sustained and committed advocacy on these issues. Our AMA is leading an advocacy campaign on P.L. 119-21 changes, and many of the resources, advocacy work, and press statements that are part of this campaign are available on a dedicated website. Beyond this public-facing advocacy, our AMA is directly engaged with policymakers at the state and federal levels, urging policies that will implement P.L. 119-21's cuts in the least harmful manner possible.

Our AMA's advocacy work on P.L. 119-21 is comprehensive and includes the specific issue of medical frailty raised by the proposed amendment. When the Centers for Medicare & Medicaid Services issued an interim final rule that adopted stringent requirements for medical frailty exemptions, our AMA, responding to unconfirmed reports that the rule would include unduly harsh requirements, had already sent a public letter to CMS urging the agency not to adopt these requirements. Now that the rule is public, our AMA will continue to advocate vigorously for revisions that will avoid inflicting unnecessary harm to eligible patients and burden on physicians.

Finally, your Reference Committee believes it is inadvisable to adopt policy that effectively prioritizes one set of Medicaid issues above other Medicaid issues. Our policies are long-lasting, and today's priorities may not be the same as tomorrow's priorities. Competing policies that elevate different aspects of Medicaid could create confusion and undermine our advocacy as new challenges arise.

Therefore, in lieu of adopting the proposed amendment, your Reference Committee recommends reaffirmation of the AMA policies that collectively provide robust guidance and direction for the AMA's advocacy. Specifically, Policy H-290.951, "Preservation of Medicaid," elevates Medicaid to an urgent and top legislative advocacy priority and supports protecting and preserving Medicaid as an essential component of the healthcare safety net. Policy D-290.970, "Call for Action by the

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American Medical Association to Reverse or Mitigate Medicaid Cuts," denounces cuts to Medicaid and directs AMA to continue advocacy efforts to reverse or mitigate Medicaid funding reductions in P.L. 119-21 to ensure continued access to care. Policy H-290.961, "Opposition to Medicaid Work Requirements", states that AMA opposes work requirements for Medicaid eligibility, recognizing they may hinder access for vulnerable populations. Policy H-258.898, "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding," supports the use of certain financing tools, sharply curtailed by P.L. 119-21, that states have long used to support their Medicaid programs.

These reaffirmed policies, alongside AMA's robust advocacy and the provisions of Resolution 243, sufficiently address the concerns raised. Therefore, your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, existing policy be reaffirmed, and that the remainder of the report be filed.

Preservation of Medicaid H-290.951

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility.
2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts D-290.970

1. Our American Medical Association publicly denounces cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025").

2. Our AMA through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid,

3. Our AMA will continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21.

4. Our AMA will report back to the AMA's House of Delegates at A-26.

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding H-285.898

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1. Our American Medical Association supports the use of broad-based, uniform Provider (hospital and nursing home) and Managed Care Organization (MCO) taxes to generate state funds to match with federal Medicaid funding that sustain or improve Medicaid patients' access to care while not financially burdening physician practices.
2. Our AMA opposes federal proposals that would restrict or eliminate states' ability to assess Provider (hospital and nursing home) and Managed Care Organization Taxes to finance their Medicaid programs and protect patient access to care, as long as physician practices are not financially harmed.

(17) BOARD OF TRUSTEES REPORT 28 - ACCOUNTABILITY IN THE USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION

RECOMMENDATION A:

Your Reference Committee recommends that recommendation 1.2 of Board of Trustees Report 28 be amended by addition and deletion to read as follows:

2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to appeal and to review by 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, (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request ~~qualified, specialty appropriate clinicians~~, and (c) who are not incentivized to deny coverage for care~~, and~~ to ensure that automated systems do not supplant individualized clinical judgment.

RECOMMENDATION B:

Your Reference Committee recommends that recommendation 1.3 of Board of Trustees Report 28 be amended by addition and deletion to read as follows:

3) Support and seek advancement of federal legislation to promote transparency in all ~~Medicare Advantage~~ prior authorization programs, including public reporting of AI and automated decision-making use.

RECOMMENDATION C:

Your Reference Committee recommends that recommendation 1.5 of Board of Trustees Report 28 be

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amended by addition and deletion to read as follows:

5) Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI generated recommendations without direct review of the patient record by a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided and (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request ~~qualified clinician~~.

RECOMMENDATION D:

Your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 24 is adopted as amended, and the remainder of the Report filed.

ADOPTED LANGUAGE:

1) Our American Medical Association (AMA) will:

1. **Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature.**
2. **Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to appeal and to review by 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, (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request, and (c) who are not incentivized to deny coverage for care, and to ensure that automated systems do not supplant individualized clinical judgment.**
3. **Support and seek advancement of federal legislation to promote transparency in all prior authorization programs, including public reporting of AI and automated decision-making use.**
4. **Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations.**
5. **Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI-generated recommendations without direct review of the patient**

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record by 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 and (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request.

6. **Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity denials and promote clinician oversight, audit authority, and protections against algorithmic discrimination.**
7. **Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty. (Directive to Take Action)**

2) That item two of Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

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

1) Our American Medical Association (AMA) will:

1. Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature.
2. Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to review by qualified, specialty-appropriate clinicians who are not incentivized to deny coverage for care, and to ensure that automated systems do not supplant individualized clinical judgment.
3. Support and seek advancement of federal legislation to promote transparency in Medicare Advantage prior authorization programs, including public reporting of AI and automated decision-making use.
4. Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations.
5. Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI-generated recommendations without direct review of the patient record by a qualified clinician.
6. Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity denials and promote clinician oversight, audit authority, and protections against algorithmic discrimination.

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7. Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty. (Directive to Take Action)

2) That item two of Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Your Reference Committee heard testimony reflecting a strong consensus in support of Board of Trustees Report 28. However, an amendment was offered to ensure that under recommendation 1.2 and 1.5 there is consistency in the definition of "qualified specialty-appropriate physician" with H-480.931, where it is defined as 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. Another amendment asked for an expansion of the scope of recommendation 1.4 beyond Medicare Advantage to also include all payers. Both amendments were supported by your Board of Trustees.

Your Reference Committee agrees with the adoption of these amendments. Therefore, your Reference Committee recommends Board of Trustee Report 28 be adopted as amended and the remainder of the report be filed.

(18) RESOLUTION 203 - SUPPORT FOR INDEPENDENT EVALUATION OF OUTCOMES ASSOCIATED WITH UNSUPERVISED NURSE PRACTITIONER PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for and support funding of independent, academically rigorous studies performing comparative effectiveness analyses of patient outcomes between autonomous non-physician practitioners and physician-led (MD/DO) team based care models, including measures of patient safety, quality, utilization, access, cost, and health outcomes, with a goal of publication in peer-reviewed scientific journals ~~and support funding of independent, academically rigorous studies comparing patient outcomes between unsupervised nurse practitioner care and physician-led team-based care, including measures of patient safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-reviewed literature~~. (Directive to Take Action)

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RECOMMENDATION B:

Your Reference Committee recommends that Resolution 203 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 203 be changed to read as follows:

SUPPORT FOR EVALUATION OF OUTCOMES ASSOCIATED WITH NON-PHYSICIAN PRACTITIONER PRACTICE

HOD ACTION: Resolution 203 is adopted as amended with a change of title.

ADOPTED LANGUAGE:

SUPPORT FOR EVALUATION OF OUTCOMES ASSOCIATED WITH NON-PHYSICIAN PRACTITIONER PRACTICE

RESOLVED, that our American Medical Association fund independent, academically rigorous studies performing comparative effectiveness analyses of patient outcomes between autonomous non-physician practitioners and physician-led (MD/DO or foreign equivalent) care models, including measures of patient safety, quality, utilization, access, cost, and health outcomes, with a goal of publication in peer-reviewed scientific journals. (Directive to Take Action)

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

Your Reference Committee heard extensive testimony in support of Resolution 203. Commentors broadly called for reinstatement of language calling on the AMA to support funding of studies on outcomes associated with unsupervised practice by non-physicians, and further recommended that cost be added to the enumerated measures to be examined. Your Reference Committee agrees with both recommendations and otherwise finds that the language offered in the preliminary report is sufficient to encompass studies addressing a broad range of practice models and patient outcomes. Your Reference Committee therefore recommends that Resolution 203 be adopted as amended.

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(19) RESOLUTION 207 - ADDRESSING RURAL MATERNITY CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

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

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 207 be amended by addition of a new resolve as follows:

RESOLVED, That policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 207 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 207 be changed to read as follows:

ADDRESSING RURAL CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM

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HOD ACTION: Resolution 207 is adopted as amended with a change of title.

ADOPTED LANGUAGE:

ADDRESSING RURAL CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM

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

- **advocate for the redistribution (or recapture) of unused waivers.**

RESOLVED, That policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

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

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

Testimony for Resolution 207 reflected the importance of the Conrad 30 Waiver Program to communities facing health care access challenges. Testimony appreciated the resolution's creative and timely approach to addressing workforce shortages. However, commenters noted that some aspects of the resolution are covered by existing AMA policy, and that our AMA is already engaged in extensive work in this space, supporting legislation to expand the Conrad 30 program, allow for the redistribution of unused Conrad 30 slots, and more. An amendment was proposed to remove potentially divisive wording relating to the distribution of waiver slots among states. Finally, one commenter suggested, in addition to taking action on Resolution 207, that existing AMA policies supporting immigration policies that address health care workforce issues be reaffirmed.

Your Reference Committee agrees that Resolution 207 adds to our AMA's existing body of policy to the extent that it explicitly calls for the redistribution or recapture of unused Conrad 30 waivers. However, your Reference Committee found the proposed amendments and the rationale surrounding ensuring that the Conrad 30 Program remains bipartisan highly persuasive. Your Reference Committee also favors changing the title of the resolution to remove the reference to "maternity care deserts" because the resolution itself does not explicitly reference maternity care deserts and the Conrad 30 Program is not solely or primarily related to addressing maternity care deserts. However, your Reference Committee does note that there are additional J-waiver programs such as the

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HHS Exchange Visitor J-1 Visa Waiver Program where additional maternity care is provided in high need areas by our international medical graduates.

Your Reference Committee appreciates the growing lack of maternity care and supports creative approaches to help and mitigate these shortages. Your Reference Committee also supports the Conrad 30 Program being used to supplement shortage areas where appropriate. However, your Committee believes that the Conrad 30 Program and our current AMA advocacy are already broad enough to support Conrad 30 slots being filled by physicians that provide maternal care. Furthermore, your Reference Committee heard that the states that are currently most in need are having the hardest time recruiting Conrad 30 participants. Testimony noted that the resolution as written would not help to mitigate this problem and instead would incentivize these individuals to go to the states that are already considered more desirable and are currently able to fill all of their slots.

In addition, your Reference Committee agrees with the suggestion to reaffirm existing AMA policies that support removing immigration-driven barriers to strengthening our health care workforce. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended, and that existing AMA policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

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

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing

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for international medical graduates matched into U. S. residency and fellowship programs.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

(20) RESOLUTION 208 - INCORPORATING CRITICAL MEDICAL TREATMENT PLANNING INTO EMERGENCY/DISASTER PREPAREDNESS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the development of ~~develop model state~~ legislation and/or ~~and~~ guidelines that ~~for~~ incorporate~~in g~~ critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support the development of legislation and/or guidelines that incorporate critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

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

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

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

Your Reference Committee heard testimony from numerous commenters supporting Resolution 208, including testimony that emphasized the importance of ensuring continuity of critical medical treatments such as dialysis, chemotherapy, and advanced therapies during disasters and emergencies. Several comments highlighted the value of interdisciplinary and cooperative planning agreements to maintain access to care for medically vulnerable populations.

Online testimony raised substantive concerns regarding the directive for our AMA to develop model state legislation. Multiple commenters stressed that disaster and emergency management is a specialized field with highly localized needs, regulatory frameworks, and technical standards that vary widely across jurisdictions. While the intent to support continuity of care is broadly supported, testimony found the model legislation directive overly prescriptive and outside our AMA's core expertise.

Your Reference Committee agrees that continuity of critical medical treatments during disasters and emergencies is an important priority for our AMA. However, your Reference Committee believes our AMA can make the greatest contribution by supporting guidance, best practices, and cooperative planning efforts that can be adapted to differing state and local circumstances, rather than by developing prescriptive model legislation. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

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(21) RESOLUTION 212 - PROTECTING PATIENT ACCESS TO CLINICAL TRIALS AND MITIGATING ADMINISTRATIVE DISRUPTIONS TO NIH FUNDING

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 212 be amended by addition and deletion to read as follows:

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

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

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

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate against (1) any delay or inappropriate interference by the Office of Management and Budget (OMB), or any other entity within the Executive Branch, in the approval, apportionment, or distribution of funds appropriated to the NIH, and (2) any other administrative actions that ~~for the immediate approval of the NIH spend plan and the full apportionment of congressionally appropriated funds by the Office of Management and Budget (OMB), and advocate against any future use of administrative apportionment delays to artificially~~ restrict or impound biomedical research funding (Directive to Take Action); and be it further

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RECOMMENDATION C:

Your Reference Committee recommends that Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 is adopted as amended.

ADOPTED LANGUAGE:

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

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

- **a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities;**
- **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; or**
- **c. is driven by frameworks that bypass validated, merit-based scientific peer-review processes or violate ethical obligations to human subjects. (Modify Current HOD Policy); and be it further**

RESOLVED, that our AMA advocate against (1) any delay or inappropriate interference by the Office of Management and Budget (OMB), or any other entity within the Executive Branch, in the approval, apportionment, or distribution of funds appropriated to the NIH, and (2) any other administrative actions that restrict or impound biomedical research funding (Directive to Take Action); and be it further

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

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

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

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

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

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

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

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

Your Reference Committee heard extensive testimony in favor of Resolution 212's core goal of safeguarding funding for the National Institutes of Health (NIH). Our AMA has actively supported funding for NIH research, including through letters to Congressional appropriators seeking adequate NIH funding levels, letters opposing caps on indirect cost recovery for NIH grants, and public statements on the importance of NIH funding for medical research. Your Reference Committee heard testimony that Resolution 212 would expand on our AMA's existing body of policy in this area, allowing for continued effective advocacy.

A friendly amendment, which received support, was offered and would clarify that our AMA will advocate against a reorganization, consolidation, or reprioritization of NIH funding that meets any of the listed criteria (as opposed to all three), and would change the second resolved clause to accurately reflect recent developments to the status of 2026 NIH funding and generalize the policy to allow our AMA to oppose future administrative actions that interfere with NIH or biomedical research funding. Your Reference Committee agrees that this amendment captures the spirit of the original resolution while making useful modifications to update and expand the language. Therefore, your Reference Committee recommends that Resolution 212 be adopted as amended.

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(22) RESOLUTION 216 - PROTECTING HEALTHCARE AS A SENSITIVE LOCATION

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 216 be amended by deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 is adopted as amended.

ADOPTED LANGUAGE:

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

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

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

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

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

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

Your Reference Committee heard extensive testimony in strong support of Resolution 216. Testimony highlighted the negative impact of federal immigration enforcement activities in healthcare facilities on patient and clinician safety, trust, and public health outcomes.

Multiple commenters supported amending the second resolved clause by removing the word “inappropriate,” arguing that its inclusion introduces ambiguity and legal uncertainty. Your Reference Committee agrees that the deletion of “inappropriate” clarifies the resolution, preventing subjective interpretation and avoiding the need for referral for further definition. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(23) RESOLUTION 219 - INCORPORATING EVIDENCE-BASED LIFESTYLE MEDICINE INTO RURAL HEALTH TRANSFORMATION PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage State ~~Constituent~~ Medical Associations to work collaboratively with their ~~respective~~ State Departments of Health to incorporate ~~implementation of~~ the principles and practices of lifestyle medicine into ~~within the design of~~ their ~~respective~~ State’s Rural Health Transformation Program initiatives, ~~thereby satisfying some of the scored requirements/categories of the Rural Health Transformation Program application~~; and be it further

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RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage State ~~Constituent~~ Medical Associations to work collaboratively with their ~~respective~~ State Departments of Health to offer ~~include~~ nutrition continuing medical education as part of ~~an effective strategy to satisfy one of the scored requirements/categories of~~ the Rural Health Transformation Program ~~application~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association encourage State Medical Associations to work collaboratively with their State Departments of Health to incorporate the principles and practices of lifestyle medicine into their State's Rural Health Transformation Program initiatives (New HOD Policy); and be it further

RESOLVED, that our AMA encourage State Medical Associations to work collaboratively with their respective State Departments of Health to offer nutrition continuing medical education aspart of the Rural Health Transformation Program. (New HOD Policy)

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

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

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Your Reference Committee heard testimony from many commenters supporting Resolution 219. Your Reference Committee heard that addressing chronic disease and health disparities in rural communities through evidence-based lifestyle medicine and enhanced nutrition education is urgently needed, and that lifestyle medicine aligns closely with preventive health strategies and the core goals of Rural Health Transformation Program (RHTP) initiatives, with testimony citing direct benefits for patient outcomes, clinician preparedness, and rural system sustainability.

A friendly amendment was offered to clarify the resolution by encouraging collaboration with state departments of health and the inclusion of lifestyle medicine in RHTP implementation, rather than prescribing mandatory continuing education requirements or targeting already submitted state applications. Testimony argued that the proposed amendment ensures the resolution is consistent with current program realities, provides flexibility for state associations, while maintaining the resolution's focus on supporting evidence-based and scalable approaches without creating new mandates.

Your Reference Committee favors adopting Resolution 219 with this amendment, as it preserves the resolution's intent to strengthen rural health and promote evidence-based preventive care while clarifying the resolution's language and supporting our AMA's ongoing state-level collaboration in RHTP implementation. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

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(24) RESOLUTION 229 - PHYSICIANS ARE NOT PROVIDERS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 229 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term "physician" when discussing those with an MD or DO~~, and either "clinician" or "health care professional" as appropriate to describe those with other varying credentials~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA believes that the use of the term "provider" when used to include physicians negatively impacts ~~evaluate the issue of overbroad terminology using Provider for Physician and others be evaluated for effect on~~ patient education~~/~~ and awareness, transparency and the ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the fourth resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA refer the issue of "Physicians are not Providers" ~~to the board for study and report back including~~ for possible consideration by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA).

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 229 be adopted as amended.

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HOD ACTION: Resolution 229 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term "physician" when discussing those with an MD or DO (Directive to Take Action); and be it further

RESOLVED, that our AMA Oppose the use of the term "provider" when used to include physicians (New HOD Policy); and be it further

RESOLVED, that our AMA believes that the use of the term "provider" when used to include physicians negatively impacts patient education and awareness, transparency and the ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RESOLVED, that our AMA refer the issue of "Physicians are not Providers" for possible consideration by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term "physician" when discussing those with an MD or DO, and either "clinician" or "health care professional" as appropriate to describe those with other varying credentials (Directive to Take Action); and be it further

RESOLVED, that our AMA Oppose the use of the term "provider" when used to include physicians (New HOD Policy); and be it further

RESOLVED, that our AMA evaluate the issue of overbroad terminology using Provider for Physician and others be evaluated for effect on patient education/awareness, transparency and ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RESOLVED, that our AMA refer the issue of "Physicians are not Providers" to the board for study and report back including possible consideration by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)

Your Reference Committee heard extensive testimony in support of Resolution 229. Commenters noted that using the term "provider" to refer to physicians minimizes the education, training, expertise, and licensure of physicians and can be misleading to patients.

Multiple friendly amendments were offered, including one that would strengthen the resolution by positively stating, in the third resolved clause, that our AMA believes that referring to physicians as "providers" has negative impacts, rather than calling on our AMA to study the issue, and by directing our AMA, in the fourth resolved clause, to immediately

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refer the issue for possible consideration by the AMA Council on Ethical and Judicial Affairs (CEJA). Testimony noted that these amendments fell in line with our existing scope of practice work and gave the resolution immediate and direct effect as adopted policy rather than framing it as an evaluation, as these concerns are already well established. However, testimony highlighted that this issue has not been fully assessed from an ethical perspective and may warrant further consideration by the Council on Ethical and Judicial Affairs.

Your Reference Committee agrees with the goals of Resolution 229 and believes that these proposed amendments do strengthen the resolution. Your Reference Committee would further amend the resolution, in the first resolved clause, by removing the language calling for the use of the term “clinician” or “health care professional” to refer to non-physicians with other credentials, as your Reference Committee believes that it is not necessary for our AMA to take a position on this question.

Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(25) RESOLUTION 232 - BANNING FLAVORED CANNABIS E-CIGARETTES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling intoxicating hemp products ~~and public health entities~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA pursue legislative changes supporting ~~concerning~~ a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States.

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RECOMMENDATION C:

Your Reference Committee recommends that Resolution 232 be adopted as amended.

HOD ACTION: Resolution 232 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling intoxicating hemp products (Directive to Take Action); and be it further

RESOLVED, that our AMA pursue legislative changes supporting a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States. (Directive to Take Action)

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling hemp products and public health entities (Directive to Take Action); and be it further

RESOLVED, that our AMA pursue legislative changes concerning a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States. (Directive to Take Action)

Your Reference Committee heard unanimous testimony in support of Resolution 232. One commenter offered a friendly amendment with minor technical corrections to improve the clarity of the resolution. Your Reference Committee agrees with the offered amendment and, therefore, recommends that Resolution 232 be adopted as amended.

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(26) RESOLUTION 239 - MEDICARE ADMINISTRATIVE CONTRACTOR POLICY MODIFICATION

RECOMMENDATION A:

Your Reference Committee recommends that the new sixth bullet of Policy D-330.897 in the first resolve clause be amended by addition to read as follows:

Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA, LCD Reference Article, or Billing and Coding Article, and to require MACs to allow a 90-day public comment period after this explanation has been provided (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the first resolve clause of Policy D-330.987 be amended by addition of the following new seventh bullet:

7. Our AMA will support federal legislation to improve the LCD process, including to make the LCD process more transparent and responsive to stakeholders such as providers with subject matter expertise so that patients can receive medically necessary and appropriate care.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 239 be adopted as amended.

HOD ACTION: Resolution 239 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read:

1. **Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.**

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2. **Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.**
3. **Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.**
4. **Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs.**
5. **Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function.**
6. **Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA, LCD Reference Article, or Billing and Coding Article, and to require MACs to allow a 90-day public comment period after this explanation has been provided (Modify Current HOD Policy); and be it further**
7. **Our AMA will support federal legislation to improve the LCD process, including to make the LCD process more transparent and responsive to stakeholders such as providers with subject matter expertise so that patients can receive medically necessary and appropriate care.**

RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process. (Reaffirm HOD Policy)

RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read:

1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.
2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the

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effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.

3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.
4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs.
5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function.
6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process. (Reaffirm HOD Policy)

Your Reference Committee heard uniformly supportive testimony for Resolution 239 including support for a minimum 90-day public comment period for new or revised LCDs, expedited reconsideration timelines, and explanations for the removal of diagnostic codes from LCAs. An amendment was offered requiring a medical explanation for diagnostic code removal and a 90-day comment period before such a removal takes effect.

Your Reference Committee believes Resolution 239 would bolster our AMA's policies on Medicare Administrative Contractors. The amendment's "medical explanation" requirement may be overly restrictive, as there are often legitimate non-medical reasons for removing diagnostic codes, but the additional amendment offered strengthens the resolution by adding a 90-day comment period before removal takes effect. An additional amendment, which your Reference Committee accepted, supports federal legislation that would improve the LCD process. Additional testimony supported this amendment which your Committee adopted. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended.

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(27) RESOLUTION 240 - ENDING PRIVATE EQUITY DIVIDEND RECAPITALIZATION IN HEALTHCARE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 240 be amended by addition to read as follows:

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors that permit any non-physician licensed entities to exercise control over the practice of medicine (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 240 be amended by deletion to read as follows:

RESOLVED, that our AMA will develop model ~~federal and~~ state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 240 be adopted as amended.

HOD ACTION: Resolution 240 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors that permit any non-physician licensed entities to exercise control over the practice of medicine (Directive to Take Action); and be it further

RESOLVED, that our AMA will develop model state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations. (Directive to Take Action)

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RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors (Directive to Take Action); and be it further

RESOLVED, that our AMA will develop model federal and state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations. (Directive to Take Action)

Testimony on Resolution 240 was limited but generally favorable. An amendment was offered to broaden the scope of the policy's opposition to dividend recapitalization to encompass all non-physician investors, not private equity firms alone. Your Reference Committee appreciates this amendment and notes that the model bill that our AMA will develop based on this policy, pursuant to the second Resolved clause, will be friendly to physician practices. Your Reference Committee therefore recommends that Resolution 240 be adopted as amended.

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(28) RESOLUTION 243 - STANDARDIZING MEDICAL FRAILTY TO STREAMLINE MEDICAID COMMUNITY ENGAGEMENT & WORK EXEMPTIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 243 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association continue to work with ~~advocate that~~ the Centers for Medicare & Medicaid Services ~~and~~ , state Medicaid agencies, and state and specialty medical associations to establish medical frailty exemptions from Medicaid work and community engagement requirements, that are clinically grounded and protective of all individuals who are medically frail, while preserving state flexibility to build upon federal definitions and to design clinically appropriate, accessible, and locally tailored exemption processes ~~a standard with which to define "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies; this definition shall explicitly include, at a minimum, any individual currently undergoing diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a life-threatening or complex chronic medical condition, as well as conditions in which the disease or its treatment results in functional limitation or an ongoing need for medical care, while preserving the authority of states to expand these protections to additional populations~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve clause of Resolution 243 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to advocate for ~~federal and state Medicaid guidance to provide~~ automatic exemptions from community engagement and work requirements for patients and ~~primary~~ caregivers of patients with complex medical conditions, utilizing ~~evidence-based clinical data and claims-based algorithms~~ existing data to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further

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RECOMMENDATION C:

Your Reference Committee recommends that the third resolve clause of Resolution 243 be amended by addition to read as follows:

RESOLVED, that our AMA continue to advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians.; and be it further

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 243 be amended by addition of a new fourth resolve to read as follows:

RESOLVED, that our AMA continue to urge policymakers, in defining and operationalizing medical frailty exemptions, to adopt policies that encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system.

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 243 be adopted as amended.

HOD ACTION: Resolution 243 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association work the Centers for Medicare & Medicaid Services, state Medicaid agencies, and state and specialty medical associations to establish medical frailty exemptions from Medicaid work and community engagement requirements, that are clinically grounded and protective of all individuals who are medically frail, while preserving state flexibility to build upon federal definitions and to design clinically appropriate, accessible, and locally tailored exemption processes(Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients

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with complex medical conditions, existing data to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians; and be it further

RESOLVED, that our AMA urge policymakers, in defining and operationalizing medical frailty exemptions, to adopt policies that encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system.

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services and state Medicaid agencies establish a standard with which to define "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies; this definition shall explicitly include, at a minimum, any individual currently undergoing diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a life-threatening or complex chronic medical condition, as well as conditions in which the disease or its treatment results in functional limitation or an ongoing need for medical care, while preserving the authority of states to expand these protections to additional populations (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal and state Medicaid guidance to provide automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients with complex medical conditions, utilizing evidence-based clinical data and claims-based algorithms to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians. (Directive to Take Action)

Your Reference Committee heard support for the intent of Resolution 243 and agrees that individuals who are medically frail should be protected from losing Medicaid coverage due to work and community engagement requirements. Testimony emphasized the importance of ensuring that medical frailty exemptions are sufficiently broad and clinically grounded while minimizing administrative and other burdens on patients and physicians.

Since issuance of the preliminary report, additional testimony and amendment language were offered that sought to further clarify the types of conditions and circumstances that should qualify an individual for protection. Your Reference Committee appreciates these efforts and agrees that individuals undergoing diagnostic evaluation, treatment, active surveillance, or ongoing monitoring for serious health conditions may have substantial health care needs that warrant protection. The Committee also recognizes that serious medical conditions do not always fit neatly into diagnostic categories and that individuals may experience significant health care needs, functional limitations, or intensive

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interaction with the health care system even before a definitive diagnosis has been established.

Your Reference Committee combined aspects of different amendments it received into our recommendation for Resolution 243, and believes this language incorporates the strongest elements of the various proposals presented during the hearing. The amendment establishes a broad framework that encompasses the full range of serious and complex conditions. This approach positions our AMA to advocate for comprehensive protections for medically vulnerable individuals as federal and state policies continue to evolve.

Accordingly, your Reference Committee recommends that Resolution 243 be adopted as amended.

(29) RESOLUTION 244 - ELIMINATE ADMINISTRATIVE BARRIERS TO APPEAL WRONGFUL DENIALS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 244 be amended by addition and deletion to read as follows:

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 denials ~~plans~~ without requiring plan-specific forms (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 244 be adopted as amended.

HOD ACTION: Resolution 244 is adopted as amended.

ADOPTED LANGUAGE:

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 denials without requiring plan-specific forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded

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ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)

RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal plans without requiring plan-specific forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)

Your Reference Committee heard substantial testimony in favor of Resolution 244. Commenters widely view the resolution as consistent with existing AMA policy and a necessary step to reduce administrative barriers, protect patient choice, and empower physicians. A friendly amendment was offered to correct a typo in the language and was endorsed by the author of the resolution. Therefore, your Reference Committee recommends that Resolution 244 be adopted as amended.

(30) RESOLUTION 247 - COMPREHENSIVE ERISA REFORM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 247 be amended by addition and deletion to read as follows:

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 states' ~~the Texas~~ Prompt Pay laws and rules, requiring a report back at the following annual meeting.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 247 be adopted as amended.

HOD ACTION: Resolution 247 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and

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recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after states' Prompt Pay laws and rules, requiring a report back at the following annual meeting.

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)

Your Reference Committee received mixed testimony for Resolution 247. Though a strong argument was made for reaffirmation of existing AMA policy, the majority of testifiers supported adoption of the resolution. However, testimony also highlighted that with our House of Delegates having debated and adopted extensive policy addressing prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and other related issues, it is important that our advocacy relies on such AMA policy and not Texas law. While Texas law may currently align with AMA policy, laws regularly change. Testimony noted concerns that the resolution could potentially circumvent AMA policy on these issues by tethering our advocacy to Texas law. Accordingly, amendments were offered to mitigate this issue, and to remove the reference to Texas law. Your Reference Committee agrees with this amendment. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended.

(31) RESOLUTION 248 - MEDICAL STAFF OVERSIGHT OF HOSPITAL AUGMENTED INTELLIGENCE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 248 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician oversight ~~reviews~~ of ~~all~~ augmented intelligence tools and applications, including but not limited to recommendations that impact patient care (Directive to Take Action).

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 248 be adopted as amended.

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HOD ACTION: Resolution 248 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician oversight of augmented intelligence tools and applications, including but not limited to recommendations that impact patient care (Directive to Take Action).

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician reviews of all augmented intelligence tools and applications, including but not limited to recommendations that impact patient care (Directive to Take Action).

Your Reference Committee heard testimony largely in support of Resolution 248. Isolated testimony expressed concern that language in the resolution requiring medical staff at hospitals and health systems to review all AI tools and applications may be impractical if interpreted literally. Testimony therefore recommended amending this language to make it less absolute, while still preserving the important intent of physician oversight of an AI tool's application and implementation. Your Reference Committee agrees with these amendments. Therefore, your Reference Committee recommends that Resolution 248 be adopted as amended.

(32) RESOLUTION 250 - PROTECTING RESIDENT PHYSICIANS WITH PENDING IMMIGRATION STATUS AND ENSURING SAFE PARTICIPATION IN PROFESSIONAL ACTIVITIES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve clause of Resolution 250 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) urgently advocate on behalf of ~~for the Department of Homeland Security (DHS) and other relevant federal agencies to temporarily cease immigration enforcement for~~ non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched; and be it further

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RECOMMENDATION B:

Your Reference Committee recommends that the second resolve clause of Resolution 250 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support the development and dissemination of ~~develop and disseminate~~ a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 250 be adopted as amended.

HOD ACTION: Resolution 250 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association (AMA) urgently advocate on behalf of non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched; and be it further

RESOLVED, that our AMA support the development and dissemination of a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

RESOLVED, that our American Medical Association (AMA) urgently advocate for the Department of Homeland Security (DHS) and other relevant federal agencies to temporarily cease immigration enforcement for non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched; and be it further

RESOLVED, that our AMA develop and disseminate a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

Your Reference Committee heard mixed testimony on Resolution 250. Your Reference Committee heard about the rapidly shifting immigration landscape which has caused some international medical graduates (IMGs) to lose valid visa status and to be detained by the Department of Homeland Security (DHS). Your Reference Committee appreciates how difficult visa processing has been under this current Administration. However, your Reference Committee also heard that advocating for the complete cessation of immigration enforcement or physicians was too broad of an ask that would undermine our

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AMA's credibility with the Administration and decrease our chances of success in advocating on immigration issues in general. The complete cessation of enforcement would be seen as a security risk for our country.

Moreover, testimony highlighted that our AMA should support the development of resources for IMGs since there are other leading entities in this space (such as Intealth) that can and do create these resources. These entities, as the primary sponsors of physicians with J-1 visas, have additional information and subject matter expertise that should be respected, and our AMA should allow these entities to take the lead and continue to work with them. Therefore, your Reference Committee recommends that Resolution 250 be adopted as amended.

(33) RESOLUTION 252 - IMMEDIATE ACTION TO PREVENT FURTHER IMMIGRANT DEATHS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by supporting ~~actively and vocally advocating for and endorsing~~ policies that:

- make immigration status and place of birth protected health information
- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- ~~require~~ encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve be amended by deletion to read as follows:

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966~~, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety~~

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~~for all immigrants, migrants, refugees, detainees, and asylum seekers~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 252 be adopted as amended.

HOD ACTION: Resolution 252 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by supporting policies that:

- **make immigration status and place of birth protected health information**
- **prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge**
- **encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities**
- **oppose mandated inquiries about patient immigration status in health care facilities; and be it further**

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966.

RESOLVED, That AMA advocate in an urgent, timely manner to protect immigrant health, safety, and access to care as directed by HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers.

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by actively and vocally advocating for and endorsing policies that:

- make immigration status and place of birth protected health information
- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- require health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities; and be it further

RESOLVED, that our AMA supports physician and other health care worker efforts to organize in support of immigrants' right to safe and high-quality health care in medical settings; and be it further

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RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers.

Your Reference Committee heard testimony on the importance of ensuring that immigrants can safely seek and receive health care. Testimony highlighted the importance of immigrant patients feeling safe while seeking health care and noted that ensuring that medical facilities are identified as sensitive locations will help in this effort. Amendments were offered. Testimony noted that the language should be broadened to allow our AMA to support the protection of sensitive locations while still being able to aid other organizations, like the National Immigration Law Center, in areas where they should rightfully take the lead as they are the subject matter experts. Testimony further noted that our AMA cannot require health care facilities to adopt these guidelines but that our AMA can and should encourage adoption of these standards. Testimony additionally noted that our AMA will always work in an expeditious manner to ensure the implementation of our policy. Your Reference Committee notes that the offered amendments address these concerns and believes that with the amended language this Resolution will nicely support Resolution 216. Therefore, your Reference Committee recommends that Resolution 252 be adopted as amended.

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(34) RESOLUTION 254 - OMB PROPOSED RULE: REGULATION FOR FEDERAL FINANCIAL ASSISTANCE

RECOMMENDATION A:

Your Reference Committee recommends that the second clause of Resolution 254 be amended by addition to read as follows:

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 254 be adopted as amended.

HOD ACTION: Resolution 254 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference; and be it further

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026; and be it further

RESOLVED, that our AMA consider taking legal action to challenge implementation of the proposed Office of Management and Budget (OMB) rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026.

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RESOLVED, that our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference; and be it further

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule; and be it further

RESOLVED, that our AMA consider taking legal action to challenge implementation of the proposed OMB rule.

Your Reference Committee heard strong supportive testimony for Resolution 254. Testimony noted the hardships that would ensue if this proposed rule were to be passed. Your Reference Committee agrees that scientific peer review, academic independence, and merit-based research funding are foundational to medical progress and the development of biomedical innovations and public health interventions. The resolution raises valid concerns that the proposed Office of Management and Budget rule could introduce inappropriate political considerations into federal research funding decisions, grant administration, scientific dissemination, and other critical health research activities.

Your Reference Committee believes that preserving the integrity and independence of the scientific enterprise is essential to advancing patient care and protecting the nation's biomedical research infrastructure. Your Reference Committee is proposing a minor technical amendment to add the title and Federal Register citation for the proposed rule referenced in the first and second Resolved clauses. Therefore, your Reference Committee recommends that Resolution 254 be adopted as amended.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(35) RESOLUTION 201 - PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

RESOLUTION 233 - BANNING SYNTHESIZED, PURIFIED OR DERIVATIVE PRODUCTS FROM KRATOM

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 233.

PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

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

1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom, and its derivatives, 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, and its derivatives, only for personal use should not face criminal consequences.
4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further

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RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

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

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

HOD ACTION: Alternate Resolution 201 is adopted in lieu of Resolutions 201 and 233.

ADOPTED LANGUAGE:

PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

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

1. **Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.**
2. **Our AMA recommends individuals who are currently using kratom, and its derivatives, 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, and its derivatives, only for personal use should not face criminal consequences.**
4. **Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further**

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RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

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

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

RESOLUTION 201 - PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

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

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

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

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

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

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RESOLUTION 233 - BANNING SYNTHESIZED, PURIFIED OR DERIVATIVE PRODUCTS FROM KRATOM

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

Your Reference Committee agrees with the overwhelming online testimony in support of Resolution 201 and Resolution 233, which both relate to the dangers of unregulated kratom products, including 7-hydroxymitragynine (7-OH) kratom products and other synthesized, purified, or derivative kratom products. However, your Reference Committee does not agree with the proposed amendment to limit the resolution only to "commercial" entities. Your Reference Committee notes that current policies (See H-95.901 and H-95.903) emphasize that individuals using kratom or other substances for personal use should not face criminal charges. Additional testimony noted that since the Resolutions covered very similar issues, they should be combined. Your Reference Committee agrees.

Your Reference Committee further supports an amendment proffered during the Reference Committee hearing to include adverse cutaneous effects. Therefore, your Reference Committee recommends that Alternate Resolution 201, a combination of Resolutions 201 and 233, be adopted in lieu of Resolutions 201 and 233.

(36) RESOLUTION 222 - ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of Resolution 222.

ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE

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

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RESOLVED, that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

HOD ACTION: Alternate Resolution 222 is adopted in lieu of Resolution 222.

ADOPTED LANGUAGE:

ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE

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

RESOLVED, that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

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

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

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

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

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

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

Your Reference Committee heard testimony reflecting genuine concern about Medicare Advantage marketing and enrollment, including that older beneficiaries are frequently misled by aggressive advertising and inducements and often do not understand the coverage they select. Other testimony supported reaffirmation, noting that our AMA maintains an extensive body of policy addressing Medicare Advantage transparency, marketing, directory accuracy, and beneficiary privacy. An informational statement on behalf of CMS confirmed that existing federal rules already prohibit misleading marketing and inducements, require accurate provider directories, and provide enrollment protections, with recent rulemaking and legislation further strengthening directory accuracy. Testimony also distinguished the first resolved clause, which calls for a unified, official online Medicare enrollment platform that incorporates education and clear presentation of provider networks, prior authorization requirements, and out-of-pocket costs, as new policy not fully captured by existing AMA policy.

Your Reference Committee agrees that the concerns raised by the resolution are highly concerning. With respect to the first resolved clause, your Reference Committee finds that the call for a unified, official Medicare enrollment platform represents new policy worthy of adoption. As to the remaining resolved clauses, your Reference Committee finds that our AMA already maintains strong and broad policy addressing each concern, and that reaffirmation preserves our AMA's flexibility to continue advocating aggressively for Medicare Advantage accountability across prior authorization reform, denial transparency, marketing oversight, and payment integrity. Therefore, your Reference Committee recommends that the first resolved of Resolution 222 be adopted and that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Increasing Transparency Surrounding Medicare Advantage Plans H-330.862

Our AMA supports policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization

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practices, claim denials, marketing expenses, supplemental benefits, and provider networks.

Medicare Advantage Policies H-330.878

1. Our American Medical Association supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate:
    a. for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients.
    b. that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided.
    c. that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Ban on Medicare Advantage "No Cause" Network Terminations H-285.902

1. Our American Medical Association urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by:
    a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network;
    b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies;
    c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder;
    d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following:
        i. civil monetary penalties;
        ii. enrollment sanctions; or
        iii. incorporating the accuracy score into the Stars rating for each plan; e. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:

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a. requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year;
b. publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy;
c. conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; and
d. evaluating alternative/additional measures of adequacy.

3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by:
    a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form;
    b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include:
        i. the number of contracted physicians in each specialty and county;
        ii. the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and
        iii. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan.

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Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Patient Privacy and Confidentiality H-315.983

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
    c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
    d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
    e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms:
    a. that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of

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personal medical information and medical records as other patients;

b. that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;

c. that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
    a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
    b. Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
    c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
    d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for

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the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
    a. the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
    b. the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
    c. the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar

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business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

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(37) RESOLUTION 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

RESOLUTION 230 - EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 226 be adopted in lieu of Resolutions 226 and 230.

EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

RESOLVED, that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

HOD ACTION: Alternate Resolution 226 is adopted in lieu of Resolutions 226 and 230.

ADOPTED LANGUAGE:

EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

RESOLVED, that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

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RESOLUTION 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

RESOLVED, that our American Medical Association, in conjunction with other key organizations, study the potential impact of a proposed $100,000 employment-based visa fee on:

- International Medical Graduates participation in the National Resident Matching Program (NRMP) Match; and
- Graduate medical education programs; and
- Critical access hospitals; and
- Waiver and non-waiver recruitment into all specialties; and
- Physician workforce development and access to care in communities across all 50 states and U.S. territories. (Directive to Take Action)

RESOLUTION 230 - EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RESOLVED, that our American Medical Association advocate for policies that ensure appropriate consideration and avoidance of undue delays in visa processing, issuance, and entry into the United States for fully vetted international medical graduates entering to participate in accredited graduate medical education or provide patient care, while maintaining necessary security and vetting procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA monitor and report on the impact of such policies on International Medical Graduate participation, physician workforce supply, patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

Mixed testimony was received for Resolutions 226 and 230. Your Reference Committee noted that these two resolutions covered the same topic areas and had very similar asks, that of a study that explores the impact of the recent immigration changes in the United States on International Medical Graduates (IMGs) in addition to asking for advocacy surrounding visa delays. Given the overlapping asks your Reference Committee combined Resolutions 226 and 230.

Testimony highlighted the existing policy that our AMA has in this space and the extensive work that has already been done to help mitigate the $100,000 fee, address visa issues, and generally advocate for our IMG colleagues. This extensive work can be seen in the extensive work our AMA has done in this space including:

- The AMA continues to push for an exception to this proclamation for physicians and has worked intimately with Congress to get H.R. 7961, the "H-1Bs for the Physician and Healthcare Workforce Act" introduced. This bill would exempt physicians and health care workers from the $100,000 fee implemented by the Proclamation and would tie future fees to the Immigration and Nationality Act levels to ensure that this does not happen again. The legislation was introduced by

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Representatives Mike Lawler (R-NY), Sanford D. Bishop, Jr. (D-GA), Maria Elvira Salazar (R-FL), and Yvette Clarke (D-NY) and is already garnering bipartisan cosponsors. AMA grassroots have been activated, and the House bill generated solid press coverage, including an article in the New York Times featuring a quote from Dr. Mukkamala. AMA is working on introducing a companion bill in the Senate.

- On April 13, 2026, the AMA sent a letter strongly supporting H.R. 7961, the "H-1Bs for Physicians and Healthcare Workforce Act." This legislation would exempt physicians and health care workers involved in direct patient care from the $100,000 fee implemented by the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers." The legislation would also prevent future fees from exceeding limits previously established by Congress following enactment of the Immigration and Nationality Act, thus ensuring greater predictability for employers looking to hire physicians and other health care workers via H-1B visas.
- On April 15, 2026, the AMA signed onto a letter in support of the "H-1Bs for the Physicians and Healthcare Workforce Act" (H.R. 7961).

- The AMA led a sign on letter to the Department of Homeland Security (DHS) concerning the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers." The letter urged DHS to issue clarifying guidance stating that H-1B physicians' entry into the U.S. is in the national interest of the country thereby exempting them from the Proclamation and the $100,000 fee.
- Responses were received to both the AMA led sign on letter as well as to a private Congressional letter that the AMA helped to orchestrate concerning the H-1B filing fees. Additionally, the AMA initiated conversations which resulted in the New Dems letter concerning the H-1B filing fee. In addition, Reps. Yvette Clarke (D-NY) and Mike Lawler (R-NY), as well as Reps. Jill Tokuda (D-HI) and Don Bacon (R-NE), have released two other letters for members of Congress to sign requesting a blanket exemption for all health care workers from the new, higher $100K filing fee.
- The AMA has created a grassroots campaign on this issue. You can find that information here: Be Heard | Physicians Grassroots Network.
- On March 24th the AMA sent two letters advocating on behalf of international medical graduates. The first letter was to the U.S. Citizenship and Immigration Services (USCIS) in which the AMA urged USCIS to reconsider its suspension of premium processing and instead expand the premium processing option to H-1B visas so that H-1B physicians can continue to provide invaluable health care to U.S. patients. The second letter was sent to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting that they open visa processing at embassies and consulates worldwide for physicians seeking to enter the U.S. to join residency programs on July 1, 2020.
- On April 3, 2020, the AMA wrote a letter to Vice President Pence and USCIS urging the Administration to permit IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic. We also urged the Administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residency or a fellowship or are currently in training.

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- On April 14, 2020, the AMA sent a letter urging USCIS to recognize COVID-19 as an extraordinary circumstance beyond the control of the non-U.S. citizen IMG applicant or their employer and thus, expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the Administration to extend the current 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who has been furloughed or laid-off as a result of the pandemic to remain in the U.S. and find new employment.
- On May 4, 2020, the AMA sent a letter to Vice President Pence urging the Administration to allow J-1, H-1B, and O-1 International Medical Graduates (IMGs) to be exempt from any future immigration bans or limitations, so that these physicians can maintain their lawful non-immigrant status while responding to the urgent COVID-19 pandemic.
- On June 26, 2020, the AMA sent a letter to the Department of State and the Department of Homeland Security urging the Administration to consider J-1 and H-1B International Medical Graduates (IMGs) and their families' entry into the U.S. to be in the national interest of the country.
- On July 8, 2020, the AMA authored and coordinated a sign-on letter urging DOS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest of the country.
- On October 23, 2020, the AMA commented on the U.S. Department of Homeland Security's proposed rule concerning "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media." The proposed rule would have eliminated "duration of status" as an authorized period of stay.
- On February 15, 2022, the AMA submitted a statement for the record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled, "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System."
- On July 1, 2022, the AMA submitted comments on the Temporary Increase of the Automatic Extension Period of Employment Authorization and Documentation for Certain Renewal Applicants temporary final rule.
- On September 14, 2022, the AMA submitted a Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."
- On June 18, 2025, the AMA sent a letter urging the Department of State to immediately resume the scheduling of new visa appointments, especially J-1 appointments, for foreign national physicians which were paused by the U.S. Department of State in May 2025.
- On September 24, 2025, the AMA offered comments to the Department of Homeland Security (DHS) concerning DHS Docket No. ICEB-2025-0001: Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media. This proposed rule would eliminate "duration of status" for F, J, and I visa recipients, and their dependents, and instead would require adherence to an admission for a fixed time period disrupting the

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medical specialty and subspecialty training of thousands of foreign national physicians and in turn negatively impacting patient care in the United States.

- On February 27, 2026, the AMA sent a letter to the U.S. Department of Homeland Security and the U.S. Department of State urging for the exemption of physicians from the partial and complete suspension of entry into the U.S., as indicated in Proclamation 10998 entitled "Restricting and Limiting the Entry of Foreign Nationals to Protect the Security of the United States." In alignment with this request, the AMA asked that the adjudicative hold for physicians' pending benefit applications be lifted, and that reliable timelines for application review and approval be implemented, so that these individuals can continue providing much needed medical care in the U.S.
- On March 10, 2026, the AMA sent a letter to HHS concerning the U.S. Exchange Visitor Program. The letter highlighted communications that the AMA received from physicians expressing their deep concern about the current HHS administrative hold and their projected inability to meet their contractually obligated start date. Therefore, due to the current administrative delay within the Waiver Program, the AMA urged HHS to utilize emergency batch processing for physicians with July 1 start dates.

However, despite the extensive work and policy in this space, your Reference Committee acknowledges that a study was requested in both resolutions. Therefore, your Reference Committee recommends that Alternate Resolution 226 be adopted in lieu of Resolutions 226 and 230 and that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

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.

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.

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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.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

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.

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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.

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

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.

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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

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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.

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(38) RESOLUTION 238 - PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

RESOLUTION 246 - ARTIFICIAL INTELLIGENCE SCOPE OF PRACTICE

RESOLUTION 249 - BRINGING PHYSICIANS' VOICES TO THE IMPLEMENTATION OF AI PRESCRIBERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 238 be adopted in lieu of Resolution 238, 246, and 249.

PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

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.

RESOLVED, that our AMA will study emerging concepts around the regulation and licensure of autonomous artificial intelligence performing clinical functions. (Directive to Take Action).

HOD ACTION: Alternate Resolution 238 is adopted in lieu of Resolution 238, 246, and 249.

ADOPTED LANGUAGE:

PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

RESOLVED, that our American Medical Association advocate for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:

1. **integrate with the physician-led team and be used at the direction of the treating physician,**
2. **respect the continuity of care and best practices related to transitions of care,**

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3. **have transparent, auditable data demonstrating safety and efficacy,**
4. **be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and**
5. **adhere to our AMA policy on Augmented Intelligence in Health Care; and be it further**

RESOLVED, that our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, and their potential impact on the profession and the physician-patient relationship

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RESOLUTION 238 - PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

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)

RESOLUTION 246 - ARTIFICIAL INTELLIGENCE SCOPE OF PRACTICE

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)

RESOLUTION 249 - BRINGING PHYSICIANS' VOICES TO THE IMPLEMENTATION OF AI PRESCRIBERS

RESOLVED, that our American Medical Association (AMA) advocate that autonomous clinical artificial/augmented intelligence (AI) including AI prescription services, be regulated and licensed by an appropriate body, as well as be developed with physician input and operated under direct physician supervision.

Your Reference Committee heard mixed testimony on Resolutions 238, 246, and 249. Testimony was largely supportive of the intent of these resolutions and opposed referral on the grounds that it would delay action on this important issue. Testimony also strongly underscored that AI should augment, not replace, the physician. Testimony noted that this issue is directly relevant to patient care, that physician oversight is essential, and that evidence should support the use of AI in clinical settings. Other testimony supported referral, noting that the issue is complex and warrants further study. Your Reference Committee also considered amendments proffered in relation to each of the resolutions. However, there was substantial support for the alternate resolution that was proposed, which preserved original language prohibiting the use of autonomous AI as an independent diagnostic or prescriptive tool or as a care management substitute for a

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physician, while preserving our AMA's ability to continue studying issues related to licensure and to engage in ongoing discussions with appropriate interested parties. Testimony emphasized the complexity and evolving nature of this issue and indicated that the alternate resolution offers a balanced approach by establishing policy in part, while also allowing continued study by AMA staff. Therefore, your Reference Committee recommends that Alternate Resolution 238 be adopted in lieu of Resolutions 238, 246, and 249.

(39) RESOLUTION 251 - MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS

RESOLVED, that our American Medical Association solely support the appointment and retention of federal health policy leaders with medical, scientific, public health, administrative, or health policy expertise relevant to their respective roles; whose official actions and policy leadership are consistent with AMA policy, evidence-based medical practice, evidence-informed public health practice, scientific integrity, transparent decision-making, vaccine confidence, disease surveillance; and who support the independence of federal scientific advisory processes; and be it further

RESOLVED, that our AMA work with relevant entities to provide education, counseling, and informational resources that align with AMA policy to federal candidates, nominees, or appointees for health policy leadership positions.

HOD ACTION: Resolution 251 is referred.

RESOLVED, that our American Medical Association (AMA) vocally oppose federal government nominees or appointees to health policy leadership positions who demonstrate a pattern of nonadherence to high-quality scientific evidence, including evidence-based vaccination policy, or who do not have appropriate medical or scientific qualifications; and be it further

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RESOLVED, that our AMA work with relevant entities to provide good faith vaccine education, counseling, and informational resources to federal candidates, nominees, or appointees for health policy leadership positions who do not openly take evidence-based positions on vaccination.

Your Reference Committee heard mixed testimony for Resolution 251, with many speakers rising in support of adoption while a smaller, but still significant, number of speakers recommended that the resolution not be adopted, or that it be adopted with amendments. Your Reference Committee heard strong support from those who favored adoption for our AMA to take a more vocal stance against nominees and appointees to federal health policy leadership positions who lack necessary qualifications or espouse positions that are unsupported by science. Those who disagreed, while in some cases expressing their appreciation for the spirit of the resolution, argued that our AMA should focus on supporting the principles of science-based health policy, and that adopting a policy that calls on our AMA to take positions on individual nominees or candidates risks exposing our AMA to accusations of bias or partisanship, and could undermine our ability to work with officials whose candidacy we opposed. Proposed amendments included striking the first Resolved clause altogether, amending the first Resolved clause to frame the issue in terms of our AMA supporting candidates rather than opposing them, and adding a new Resolved clause calling on our AMA to develop minimum standards for federal officials.

Your Reference Committee appreciates the thoughtful testimony it received from both sides of this issue and considered Resolution 251 at length. Your Reference Committee notes that our AMA is a nonpartisan, issues-based organization. At the same time, it is undeniable that high-ranking federal health policymakers impact the issues we are concerned with. Ultimately, your Reference Committee determined that adopting Resolution 251 with amendments addressing some of the problems identified by opponents of the resolution is the best course of action.

The amended language for the first Resolved clause proposed by your Reference Committee would establish that our AMA only support the appointment and retention of federal health policy leaders who have the requisite expertise for their expected roles and whose official actions are consistent with AMA policy and sound principles of science-based public health. This approach acknowledges the key role of federal officials in shaping public health policy without committing our AMA to advocacy practices that would often be counterproductive. The amended language for the second Resolved clause proposed by your Reference Committee clarifies and broadens the original language, while preserving the spirit of the original.

Therefore, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

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(40) RESOLUTION 253 — PROTECTION OF MEDICAID BENEFICIARIES FROM POLITICALLY MOTIVATED AND PROCEDURALLY DEFICIENT FEDERAL FUNDING DEFERRALS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 253 be adopted in lieu of Resolution 253.

PROTECTION OF MEDICAID BENEFICIARIES FROM FEDERAL FUNDING DEFERRALS

RESOLVED, that our AMA opposes withholding or deferral of Medicaid funding and other financial enforcement mechanisms in a manner that is arbitrary, disproportionate, inconsistent with established legal and administrative processes, or likely to cause undue disruption to patient care or state Medicaid program operations; and be it further

RESOLVED, that our AMA advocates that 1) federal enforcement actions utilize deferral or withholding of state Medicaid funding only after a thorough and transparent administrative process, in accordance with federal laws and regulations, that provides states with meaningful notice and opportunity for corrective action and administrative and judicial review protections; 2) CMS restore or release withheld or deferred Medicaid funds when such administrative processes have not been followed; and 3) CMS carefully balance the benefits and harms of new program integrity actions and minimize harm to Medicaid beneficiaries, participating physicians, hospitals and other providers, and state program operations; and be it further

RESOLVED, that our AMA requests that the relevant congressional committees conduct timely and appropriate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

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HOD ACTION: Alternate Resolution 253 is adopted in lieu of Resolution 253.

ADOPTED LANGUAGE:

PROTECTION OF MEDICAID BENEFICIARIES FROM FEDERAL FUNDING DEFERRALS

RESOLVED, that our AMA opposes withholding or deferral of Medicaid funding and other financial enforcement mechanisms in a manner that is arbitrary, disproportionate, inconsistent with established legal and administrative processes, or likely to cause undue disruption to patient care or state Medicaid program operations; and be it further

RESOLVED, that our AMA advocates that 1) federal enforcement actions utilize deferral or withholding of state Medicaid funding only after a thorough and transparent administrative process, in accordance with federal laws and regulations, that provides states with meaningful notice and opportunity for corrective action and administrative and judicial review protections; 2) CMS restore or release withheld or deferred Medicaid funds when such administrative processes have not been followed; and 3) CMS carefully balance the benefits and harms of new program integrity actions and minimize harm to Medicaid beneficiaries, participating physicians, hospitals and other providers, and state program operations; and be it further

RESOLVED, that our AMA requests that the relevant congressional committees conduct timely and appropriate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

RESOLVED, that our American Medical Association oppose any policy or practice, regardless of stated justification, that employs the withholding of Medicaid funds as a coercive instrument directed at state governments in ways that predictably injure patients and disrupt the continuity of care for vulnerable beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that CMS immediately restore withheld Medicaid funds to affected states pending the completion of any proper administrative or judicial review process, in order to prevent irreparable harm to patients currently dependent on Medicaid-funded services (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the relevant congressional committees conduct immediate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

Your Reference Committee heard strong testimony on Resolution 253, which was proposed in response to the punitive withholding of large amounts of federal Medicaid funds in multiple states without due process. Commenters noted that in some cases federal funding has been withheld despite state compliance with federal requirements, and that there is a stark absence of process behind these federal actions. Some

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commenters characterized the withholdings as coercive and potentially politically motivated. While most speakers supported the resolution as written, an amendment was offered on the grounds that the original language is overly broad and could prevent the Centers for Medicare & Medicaid Services (CMS) from enforcing legitimate program integrity requirements.

Your Reference Committee agrees that the withholding of federal Medicaid funding without appropriate process, or in a disproportionate manner, causes substantial harm to state Medicaid programs and, consequently, to patients and physicians. At the same time, your Reference Committee is concerned that overly broad policy could be read as dismissing the need for enforcement mechanisms to combat fraud and abuse in Medicaid. As supporters of the original resolution noted, ensuring program integrity and fighting genuine fraud in Medicaid is not what they are opposed to, but rather the improper use of enforcement mechanisms.

Your Reference Committee is proposing alternate language to clarify that arbitrary, disproportionate, or procedurally deficient withholding of federal Medicaid funding—which include the cases cited by supporters of the resolution—is what our AMA opposes, rather than program integrity enforcement or anti-fraud initiatives more broadly. Your Reference Committee believes this language is responsive to the urgency of the current situation and establishes a cogent policy for when it is appropriate for CMS to utilize its statutory authority to withhold or defer funding. Therefore, your Reference Committee recommends that Alternate Resolution 253 be adopted in lieu of Resolution 253.

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RECOMMENDED FOR REFERRAL

(41) RESOLUTION 202 - USING AND DEFINING "UNSUPERVISED PRACTICE OF MEDICINE"

RECOMMENDATION:

Your Reference Committee recommends that Resolution 202 be referred.

HOD ACTION: Resolution 202 is referred.

RESOLVED, that our American Medical Association use the term "Unsupervised Practice of Medicine" (UPM) when describing statutory or regulatory efforts that allow nonphysician practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that physician-led, team-based care with appropriate physician supervision remains the gold standard for patient safety and quality care (New HOD Policy); and be it further

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

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

Your Reference Committee heard mostly supportive testimony for Resolution 202, with many commenters claiming that the term "unsupervised practice of medicine" improves clarity and accuracy in our AMA's advocacy on scope of practice issues. However, persuasive testimony for referral was also heard. Proponents of referring the resolution noted that the resolution raises many complicated and nuanced issues and would apply broadly across all of our AMA's advocacy efforts, public relations, and communications. Your Reference Committee agrees. The terminology used by the resolution is not universal and may mean different things in different jurisdictions. Furthermore, scope of practice issues are always evolving, and enshrining a single term could hamper our AMA's advocacy and community efforts with respect to emergent issues. Therefore, your Reference Committee recommends that Resolution 202 be referred for study.

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(42) RESOLUTION 206 - OVERALL HOSPITAL QUALITY STAR RATINGS / CMS STAR RATINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 206 be referred.

HOD ACTION: Resolution 206 is referred.

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

Your Reference Committee heard substantial testimony on Resolution 206 that was largely in favor of referral. Supporters of the resolution, including the author, felt that physician experience and clinical autonomy are important aspects of hospital quality not reflected in existing measures, and called for our AMA to develop physician-experience metrics that elevate physician voices. Several delegations, while supportive of the underlying goal, noted that issues in the resolution still need to be worked out and that referral would allow our AMA to get it right. Supporters of reaffirmation pointed to existing AMA policy calling for quality measures to be developed, evaluated, and implemented with input from our AMA and actively practicing physicians, and noted that there is currently no validated metric for measuring physician experience in the hospital setting, raising questions about how the resolution's proposals would be operationalized.

Your Reference Committee agrees that physician experience is a crucial factor in hospital quality, and that hospitals should create positive work environments that value physicians and prioritize their clinical judgment to avoid burnout and negative impacts on patient care. Given the strong interest in developing the physician-experience concept further, and the absence of an existing measure of physician experience in the hospital setting, your Reference Committee believes this issue would benefit from further study. Therefore, your Reference Committee recommends that Resolution 206 be referred.

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(43) RESOLUTION 221 - UNIVERSAL NEWBORN CONGENITAL CYTOMEGALOVIRUS SCREENING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 221 be referred.

HOD ACTION: Resolution 221 is referred.

RESOLVED, that our American Medical Association support state legislation and policies requiring universal newborn screening for congenital cytomegalovirus (cCMV) (New HOD Policy); and be it further

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

Your Reference Committee heard mixed testimony on Resolution 221. Some commenters supported adoption, emphasizing the significance of early cCMV detection in enabling timely interventions, improving outcomes, and preventing missed opportunities for hearing loss surveillance and therapeutic treatment.

Other commenters questioned whether universal screening meets the established criteria for population-wide testing and raised issues regarding test accuracy, the management of asymptomatic cases, and uncertainties about the benefit of early identification in some infants. Testimony also urged support for and deference to existing processes for evaluating and implementing additions to newborn screening programs. Your Reference Committee also heard testimony supporting referral of the resolution for additional study, as well as suggestions that a science-based, inclusive policy for nationwide newborn screening—rather than disease-specific mandates—may be preferable.

Given the mixed testimony, the scientific and policy questions raised, and the need for further evaluation of the appropriate role of our AMA in newborn screening recommendations, your Reference Committee agrees that further study is warranted. Therefore, your Reference Committee recommends that Resolution 221 be referred.

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(44) RESOLUTION 223 - ENSURING DUE PROCESS, TRANSPARENCY, AND HUMAN CLINICAL OVERSIGHT IN THE USE OF ARTIFICIAL INTELLIGENCE FOR HEALTH INSURANCE COVERAGE AND ELIGIBILITY DETERMINATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 223 be referred.

HOD ACTION: Resolution 223 is referred.

RESOLUTION 223 - ENSURING DUE PROCESS, TRANSPARENCY, AND HUMAN CLINICAL OVERSIGHT IN THE USE OF ARTIFICIAL INTELLIGENCE FOR HEALTH INSURANCE COVERAGE AND ELIGIBILITY DETERMINATIONS

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

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

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

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

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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)

Your Reference Committee heard minimal testimony on Resolution 223. An amendment was proffered by the author and considered by the Reference Committee, but it was ultimately found to be an issue that warranted further study. Therefore, Your Reference Committee recommends that Resolution 223 be referred.

(45) RESOLUTION 225 - REQUIRING PERIODIC FACE-TO-FACE VISITS BY BOARD-CERTIFIED SPECIALISTS WHO DELEGATE VISITS TO NON-PHYSICIAN PRACTITIONERS FOR NURSING HOME PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be referred.

HOD ACTION: Resolution 225 is referred.

RESOLVED, that our American Medical Association support federal legislation or regulation to require a minimal standard for specialist care for patients in nursing homes, such that, when a board-certified medical specialist delegates visits to nonphysician practitioners in a nursing home setting, the physician specialist must personally conduct a face-to-face evaluation of the patient either in person or via telehealth no less than every third visit. (New HOD Policy)

Your Reference Committee heard mixed testimony for Resolution 225. While some testimony supported adoption of the resolution, opposing testimony noted that the resolution as written raised concerns surrounding discouraging specialist participation in nursing home coverage arrangements and creating operational and enforcement difficulties and questioned the validity of required an evaluation every third visit. Further testimony offered amendments, including expanding the resolution to physicians generally rather than specialists, and still others recommending referral for further study. Given the diversity of opinions on this resolution and the potential for unintended consequences of adopting policy without due consideration, your Reference Committee favors referral. Therefore, your Reference Committee recommends that Resolution 225 be referred.

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(46) RESOLUTION 236 - EXTENDING AND EXPANDING THE AMA TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP TO ENSURE ACCESS AND REGULATORY CLARITY IN GENDER-AFFIRMING CARE

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve clause of Resolution 236 be referred with a report back at I-26.

RECOMMENDATION B:

Your Reference Committee recommends that the first, third, fourth, and fifth resolve clauses of Resolution 236 be adopted.

HOD ACTION: The second resolve clause of Resolution 236 is referred with a report back at I-26 and the first, third, fourth, and fifth resolve clauses of Resolution 236 are adopted.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient physician relationship, with guidance by the Task Force (Directive to Take Action); and be it further

RESOLVED, that our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report annually to the House of Delegates regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes. (Directive to Take Action)

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RESOLVED, that our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:

1. State-specific legal summaries and regulatory guidance;
2. Shield law analyses and cross-state practice considerations;
3. Privacy and HIPAA compliance best practices;
4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
5. Documentation and informed consent templates consistent with evolving legal standards;
6. Coding, billing, and reimbursement guidance;
7. Institutional policy templates and sample protocols;
8. Educational and training resources for undergraduate and graduate medical education;
9. Telehealth and interstate licensure guidance; and
10. Information regarding legal assistance and physician defense resources (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient physician relationship, with guidance by the Task Force (Directive to Take Action); and be it further

RESOLVED, that our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report annually to the House of Delegates regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes. (Directive to Take Action)

Your Reference Committee heard extensive testimony for Resolution 236. Your Reference Committee heard that many delegations and specialty groups are concerned by urgent and evolving threats to the patient-physician relationship posed by legislative and regulatory actions targeting gender-affirming care. Your Reference Committee also heard that supporters view the extension and expansion of the AMA Task Force—and creation of centralized resources—as crucial steps to guide physicians, advance advocacy, and support patient access to evidence-based care.

Your Reference Committee also heard that the landscape surrounding gender-affirming care is rapidly changing, legally complex, and controversial. Your Reference Committee

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heard various proposed amendments, including suggestions to restructure the Task Force into an ad hoc advisory committee, and clarify reporting requirements. However, your Reference Committee also heard from our Board of Trustees that they would like additional time to study the asks contained in the second resolve and ensure that these are in harmony with the existing recommendations from the Task Force, which your Board has extended. Your Reference Committee appreciates the importance of allowing this additional information to inform next steps.

Your Reference Committee appreciates that the issues raised by Resolution 236 are incredibly important, complex, and sensitive. Furthermore, your Reference Committee acknowledges that the resolution makes asks that require careful deliberation and consideration and have significant implications for our AMA. Your Reference Committee recognizes the complexity of the landscape, the variation in testimony, the multiple offered amendments, the diversity in opinions for implementation, and the fact that a Task Force on this issue could wade into topics, duties, and financial obligations that require further study. Therefore, your Reference Committee recommends that the second resolve of Resolution 236 be referred with a report due back at the 2026 Interim Meeting of the House of Delegates, and the remainder of the Resolution be adopted.

(47) RESOLUTION 241 - STRENGTHENING OUR AMA EFFORTS TOWARD CPOM PROHIBITION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 241 be referred for report back at I-26.

HOD ACTION: Resolution 241 is adopted.

RESOLUTION 241 - STRENGTHENING OUR AMA EFFORTS TOWARD CPOM PROHIBITION

RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in section 1 as follows:

"1. Our American Medical Association ~~encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under 'friendly' physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:~~ supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine." (Modify Current HOD Policy); and be it further

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RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in the introductory clause preceding subsections (a)–(c) as follows:

"~~Physicians who are contemplating corporate investor partnerships or corporate entity relationships~~ Physicians and policymakers evaluating corporate investment in physician practices should consider the following principles to ensure that any such relationships remain subordinate to physician ownership, governance, and professional medical judgment" (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (d) as follows:

"(d) ~~Physicians should ensure that contractual arrangements preserve physician autonomy in clinical decision making.~~Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (e) as follows:

"(e) ~~Physicians should carefully review contractual provisions governing governance structures, compensation arrangements, and management responsibilities when entering relationships with corporate investors.~~ Our AMA opposes stock transfer restriction agreements, "friendly PC" arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians' professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (f) to read as follows, and renumbering the subsequent subsections accordingly:

"(f) Our AMA opposes management services organizations, private equity firms, and other non-licensed entities, and their owners, officers, directors, employees, or agents, from exercising governance authority or management control within a professional medical entity in a manner that directs, controls, or unduly influences clinical decision making, physician employment conditions affecting patient care, or other decisions reserved to licensed physicians." (Modify Current HOD Policy); and be it further

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RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (g) to read as follows, and renumbering the subsequent subsections accordingly:

"(g) Our AMA opposes noncompetition, nondisclosure, non-disparagement, and non-interference clauses that restrict a physician's ability to exercise independent professional judgment, advocate for patients, report unsafe or unethical conditions, or continue caring for patients consistent with ethical and legal obligations." (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (h) as follows:

"(h) ~~Physicians should seek transparency regarding the financial and ownership structures associated with corporate investors and related entities.~~ Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity." (Modify Current HOD Policy); and be it further

RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in item 2 as follows:

"2. Physicians should understand and evaluate the financial and governance implications of corporate investment in medical practices ~~before entering such arrangements~~ and ensure that any such arrangements do not transfer ownership, governance authority, or operational control over clinical decision making to non-licensed entities." (Modify Current HOD Policy)

Your Reference Committee heard testimony establishing that Board of Trustees Report 25 and Resolution 241 serve complementary but distinct purposes and accordingly considered them separately. Testimony regarding Resolution 241 was generally favorable, though commentors were divided between recommending adoption and recommending referral. Those favoring referral emphasized that the corporate practice of medicine policy proposed in Resolution 241, while important, is highly complex and warrants careful deliberation prior to adoption, further noting that Resolution 241 would make sweeping changes to existing AMA policy, portions of which may warrant retention.

Your Reference Committee concurs that corporate intrusion on the practice of medicine is a matter of urgent concern. It likewise recognizes that Resolution 241 proposes sweeping revisions to a policy that was designed to serve as guidance to physicians navigating relationships with corporate entities, and that Resolution 241 is significant in scope and considerable in nuance. Given the highly complex nature of physician practice arrangements, before this policy is adopted, care must be taken to ensure that it does not produce unintended consequences, for example by imposing undue restrictions on practice arrangements that are functioning effectively and which preserve physician autonomy. Your Reference Committee therefore recommends that Resolution 241 be referred for report back at I-26.

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(48) RESOLUTION 242 - REDUCING EMERGENCY DEPARTMENT BOARDING THROUGH PAYMENT REFORM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 242 be referred.

HOD ACTION: Resolution 242 is referred.

RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further

RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequence. (Directive to Take Action)

Your Reference Committee heard extensive testimony on Resolution 242, with strong agreement that ED boarding is a serious and worsening problem that harms patients. However, there was a clear split between those favoring adoption with an amendment and those favoring referral. Supporters urged adoption, including a proposed amendment to protect physicians from being pressured to alter medically appropriate admission, timing, or disposition decisions to avoid boarding penalties, arguing that existing policy lacks teeth. A substantial majority of testimony, however, supported referral.

Testimony favoring referral shared the concern about boarding harms but cautioned that the resolution's central mechanism, tying hospital reimbursement to a boarding threshold, is untested and could shift pressure onto physicians and reduce physician reimbursement without addressing the system-wide drivers of boarding, including inpatient bed availability, post-acute capacity, behavioral health infrastructure, and staffing. Testimony noted that boarding is a hospital-wide and often community-wide problem. Further testimony highlighted that behavioral health patients and rural and urban facilities face distinct challenges, and that any payment-based approach would require careful guardrails that the resolution does not contain.

Your Reference Committee further notes that our AMA is actively engaged on this issue and that a Board of Trustees report on emergency department boarding, following Board of Trustees Report 04-I-25, is due at the 2026 Interim Meeting. Your Reference Committee believes the concerns raised by Resolution 242 are best addressed through that ongoing work. Therefore, your Reference Committee recommends that Resolution 242 be referred, to be combined with the forthcoming report.

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RECOMMENDED FOR NOT ADOPTION

(49) RESOLUTION 245 - STATE REGULATION OF NON-PREEMPTED "NON-CENTRAL MATTERS" OF ERISA PLANS—RUTLEDGE V. PCMA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 245 be not adopted.

HOD ACTION: Resolution 245 is not adopted.

RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices (Directive to Take Action); and be it further

RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians (Directive to Take Action); and be it further

RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including:

1. Interest payments on overdue "clean" health insurance claims not otherwise addressed by ERISA's statutory mandate;
2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources;
3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan;
4. Payment for the administrative burden of prior authorization and successful denial appeals;
5. Parity for telehealth-delivered services;
6. Timely payment of "clean claims" when the insurer's obligation to pay the claim is reasonably distinct from timely determination of claims;
7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies;

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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)

Your Reference Committee received mixed testimony for Resolution 245. Though some supportive testimony was received, very convincing testimony noted the legal inaccuracies that are espoused in Resolution 245. Testimony noted that the *Rutledge* Supreme Court case mentioned in Resolution 245 did not fundamentally change ERISA preemption and subsequent cases interpreting *Rutledge* have made this clear. Further testimony noted that our AMA ERISA experts already gave the requested education presentation to the PPPS earlier at this meeting and our AMA gave a similar educational presentation to the entire Federation this year. Testimony also highlighted that our AMA has also developed an extensive issue brief discussing *Rutledge*, subsequent cases interpreting *Rutledge*, and how different state legislative strategies might be treated under *Rutledge* and subsequent cases, including credentialing and recoupment. The issue brief is available on the AMA website and the issue brief is regularly updated to reflect new cases interpreting *Rutledge* and/or ERISA preemption of state law. The issue brief was just updated in May. Given the legal precedence and the past and ongoing work that our AMA has undertaken in this space your Reference Committee agrees with the testimony that was provided in opposition to this Resolution. Therefore, your Reference Committee recommends that Resolution 245 not be adopted.

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RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(50) RESOLUTION 204 - D-400.982 REVISION

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, D-385.945, D-390.922, and D-400.981 be reaffirmed in lieu of Resolution 204.

HOD ACTION: Resolution 204 is adopted as amended.

ADOPTED LANGUAGE:

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

1. **Our American medical Association will increase media awareness around the 2024 AMA Annual Meeting about the need for Medicare payment reform eliminating budget neutrality reductions, and instituting annual cost of living increases.**
2. **Our AMA will step up it's public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.**
3. **Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare payment reform.**
4. **Our AMA will advocate for abolition of all MIPS penalties in light of current inadequacies of Medicare payments. (Reaffirm HOD Policy); and be it further**

RESOLVED, that our AMA will report back on a biannual basis to AMA members via open forum on Medicare Payment Reform initiatives and advocacy on Medicaid. (Directive to Take Action)

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

1. Our American medical Association will increase media awareness around the 20 24 AMA Annual Meeting about the need for Medicare payment reform eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up it's public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare payment reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of current inadeq uacies of Medicare payments. (Reaffirm HOD Policy); and be it further

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

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Your Reference Committee heard mixed testimony on Resolution 204. Supporters of adoption stressed the vital importance of Medicare physician payment reform and argued that quarterly updates to the House of Delegates on our AMA's Medicare payment reform initiatives will increase transparency. Supporters of reaffirmation note that our AMA has extensive policy on Medicare payment reform and is heavily engaged in advocacy and operational work on the issue. This work includes the Fix Medicare Now grassroots campaign, the Characteristics of a Rational Medicare Payment System principles, and the AMA National Advocacy Conference, and ongoing legislative advocacy on permanent MEI-based updates, budget neutrality reform, MIPS reform, and APM expansion. With respect to transparency, the Board of Trustees provides biannual reports on our AMA's efforts, as well as additional updates when events dictate. Multiple commenters question whether quarterly reporting requirements will be overly burdensome without meaningfully advancing transparency compared to the existing schedule.

Your Reference Committee believes that existing AMA policies already address the issues raised by Resolution 204 and shares the concerns raised about a quarterly reporting schedule. Your Reference Committee notes that reports take time to generate and are subject to internal review processes, and notes that a quarterly schedule will not provide sufficient turnaround time for the Board of Trustees and AMA staff to produce high quality reports with new meaningful information. Our AMA maintains extensive policy and active advocacy on Medicare physician payment reform, and the Board of Trustees already reports to the House biannually, with additional updates as events dictate. Therefore, your Reference Committee recommends that existing AMA policies D-400.982, D-385.945, D-390.922, and D-400.981 be reaffirmed in lieu of Resolution 204.

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.

Advocacy and Action for a Sustainable Medical Care System D-385.945

1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.

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3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

Physician Payment Reform and Equity D-390.922

Our American Medical Association will implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

Increasing Transparency of AMA Medicare Payment Reform Strategy D-400.981

1. Our American Medical Association will provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.
2. Our AMA will share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.

(51) RESOLUTION 205 - REPEAL OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, H-390.838, H-478.986, D-390.949, and D-395.999 be reaffirmed in lieu of Resolution 205.

HOD ACTION: Existing AMA policies D-400.982, H-385.905, H-390.838, H-478.986, D-390.949, and D-395.999 are reaffirmed in lieu of Resolution 205.

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

RESOLVED, that our AMA advocates for immediate administrative relief in MIPS, including expanded low-volume and hardship exemptions for rural and small practices, shortened/streamlined reporting requirements, and reduction of reporting complexity until MIPS is repealed. (Directive to Take Action)

Your Reference Committee heard testimony for Resolution 205 that was split between commenters supporting adoption and those supporting reaffirmation of existing AMA policies. Supporters of adoption point to the harmful impacts of the Merit-based Incentive Payment System (MIPS), which are disproportionately borne by small and rural practices. However, supporters of reaffirmation argue that existing AMA policies adequately respond to the harms of MIPS, and further argue that our AMA should maintain a flexible policy that can accommodate advocacy for either the full repeal of MIPS or for MIPS reform, depending on the circumstances and the legislative environment.

Your Reference Committee believes that existing AMA policy adequately addresses the concerns raised by Resolution 205. Therefore, your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, H-390.838, H-478.986, D-390.949, and D-395.999 be reaffirmed in lieu of Resolution 205.

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.

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.

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.

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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.

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.

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.

(52) RESOLUTION 210 - ELIMINATING PRESCRIPTION DRUG ADHERENCE (PDA) AS A QUALITY METRIC TIED TO PHYSICIAN RATINGS OR COMPENSATION

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-180.976 and D-450.958 be reaffirmed in lieu of Resolution 210.

HOD ACTION: Existing AMA policies D-180.976 and D-450.958 are reaffirmed in lieu of Resolution 210.

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RESOLVED, that our American Medical Association advocate against the use of patient Prescription Drug Adherence (PDA) as a quality metric tied in any manner to physician ratings or compensation. (Directive to Take Action)

Your Reference Committee heard support both for adoption of Resolution 210 and for reaffirmation of existing policy. Supporters of adoption argued that this quality measure is onerous and largely outside physician control, and that the existing cited policies are too narrow, contending that the principles should apply broadly to all medications rather than being limited to pain-related measures. Supporters of reaffirmation noted that existing AMA policy already directs advocacy against the use of adherence-related measures in physician assessment, payment, and survey programs, and supports quality metrics based on factors that physicians and health plans can reasonably control. Testimony also highlighted the strength and breadth of existing AMA policy in this area.

Your Reference Committee agrees that physicians should not be held accountable through ratings or compensation for patient adherence, which is largely outside their control, and finds that existing AMA policy is sufficient to allow our AMA to address the concerns raised. Therefore, your Reference Committee recommends that existing AMA policies D-180.976 and D-450.958 be reaffirmed in lieu of Resolution 210.

Minimum Payer Communication Quality Standards D-180.976

1. Our AMA advocates for payer minimum quality standards to include immediate access to a live representative during business hours.
2. Our AMA advocates for the adoption of physician/provider satisfaction quality metrics for Medicare Advantage plan star ratings to measure the efficiency of health plan customer service, addressing provider questions and concerns, payment efficiency, and resolution of appeals.

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

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.

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(53) RESOLUTION 211 - PREVENTING HOSPITAL-BASED 340B PROGRAMS FROM UNFAIRLY COMPETING WITH INDEPENDENT PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-110.985 be reaffirmed in lieu of Resolution 211.

HOD ACTION: Resolution 211 is referred.

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)

Your Reference Committee heard mixed testimony for Resolution 211. Testimony provided by the author in opposition to reaffirmation emphasized the need for broader 340B reform and argued that the current structure has created an uneven playing field. However, the majority of testimony supported reaffirmation of existing policy, expressing concern that expanding the program in this manner would be impracticable and would not address the underlying flaws of the 340B program. Testimony also noted concerns about the assumptions underlying the resolution and whether the proposed approach would meaningfully improve patient care. Testimony emphasized that our AMA already has strong policy on 340B that broadly addresses these concerns. Your Reference Committee agrees that, although 340B remains in need of reform, reaffirmation of existing AMA policy is the most appropriate recommendation. Therefore, your Reference Committee recommends that existing AMA policy H-110.985 be reaffirmed in lieu of Resolution 211.

340B Drug Discount Program H-110.985

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;

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and (6) supports 340B programs funded by HRSA grants provided 340B funds are utilized for the care of low-income and underserved patients as legislatively intended.

(54) RESOLUTION 214 - MEDICAL STUDENT LOANS SHOULD NOT BE CAPPED

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-305.924 and H-305.925 should be reaffirmed in lieu of Resolution 214.

HOD ACTION: Existing AMA policies H-305.924 and H-305.925 are reaffirmed in lieu of Resolution 214.

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

Your Reference Committee heard substantial testimony on Resolution 214, with many commenters supporting adoption of the resolution or adoption with amendments to keep the language broad and avoid tying it to a specific law. Most commenters agreed that imposing arbitrary caps on federal student loans does not address the high costs of medical education or the issue of student debt. However, others noted that increasing loan amounts does not resolve the debt crisis either, and more structural changes, such as shortening the duration of medical school, are needed.

Additional commenters also supported reaffirmation, noting that our AMA has already actively opposed caps on federal student loans, sent multiple advocacy letters, and engaged Congress and regulatory agencies to preserve student access to education financing and flexible repayment programs.

Your Reference Committee agrees that our AMA is already engaged in substantial work in the student loan space. Our AMA is actively engaged with Congress on the issue, including through comments on proposed changes to federal student loans in H.R. 1 (the "One Big Beautiful Bill Act") and recommending that Congress exempt physicians from student loan restrictions in a March 2026 Statement for the Record on "Advancing the Next Generation of America's Health Care Workforce." Our AMA also has continued to actively engage with the Department of Education, including by commenting on proposed changes to the Public Service Loan Forgiveness (PSLF) Program and by responding to proposals to cap federal student loans and minimize loan repayment pathways. These examples demonstrate that existing policy already supports a positive advocacy approach that is responsive to the concerns raised in Resolution 214.

Moreover, your Reference Committee notes that our existing AMA policy advocates for "federal student loan limits that accurately reflect the cost of attendance of graduate

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medical education programs." This approach is desirable because a lack of loan limits may remove medical school guardrails that prevent schools from arbitrarily and steeply raising their tuition prices. Your Reference Committee notes that our AMA also supports ensuring that tuition remains in check. Your Reference Committee wants to ensure that as many people as possible can afford medical school. However, the Committee believes that exiting policy better achieves this goal.

Therefore, your Reference Committee recommends that existing AMA policies H-305.924 and H-305.925 be reaffirmed in lieu of Resolution 214.

Restore and Enhance Federal Loan Programs for Medical Education H-305.924

1. Our American Medical Association will continue to advocate for federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs.
2. Our AMA will continue to support diverse and beneficial repayment plans for federal student loans, including income-based repayment plans that are favorable to individuals who took out loans for graduate medical education.
3. Our AMA will continue to advocate for the protection of the Public Service Loan Forgiveness (PSLF) Program for physicians.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and

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b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;

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d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
    g. Adding the ability to refinance Federal Consolidation Loans.
    h. Eliminating the cap on the student loan interest deduction.
    i. Increasing the income limits for taking the interest deduction.
    j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
    k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.

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l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and

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benefits of program appointment information on the employer's PSLF program qualifying status.

f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,

g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

j. Monitor the denial rates for physician applicants to the PSLF.

k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.

l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.

m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews,

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and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

(55) RESOLUTION 215 - OPPOSE MEDICARE EFFICIENCY ADJUSTMENTS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-400. 972, H-390.849, and D-400.982 be reaffirmed in lieu of Resolution 215.

HOD ACTION: Existing AMA policies H-400. 972, H-390.849, and D-400.982 are reaffirmed in lieu of Resolution 215.

RESOLVED, that the American Medical Association support all efforts, whether by legislation or regulation, to restrict the use of arbitrary new factors such as the efficiency adjustment used in the 2026 Medicare Physician Payment Schedule. (New HOD Policy)

Your Reference Committee received testimony for Resolution 215 that noted strong opposition to the newly introduced “efficiency adjustment” in the 2026 Medicare Physician Fee Schedule, and support for strong AMA advocacy against such arbitrary payment reductions. Though mixed testimony was received, multiple commenters noted support for reaffirmation, with some emphasizing recent AMA advocacy efforts demonstrate that existing policy already supports a strong response to the efficiency adjustment.

Your Reference Committee notes that our AMA has spoken out repeatedly against the efficiency adjustment, including in a September 2025 comment letter to CMS Administrator Mehmet Oz. More broadly, the principles espoused by our AMA in its Medicare payment reform efforts effectively argue against the arbitrary efficiency

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adjustment cuts. Given these efforts, your Reference Committee believes that existing AMA policy is sufficient to allow for targeted advocacy against the efficiency adjustments alongside support for structural Medicare payment reforms. Therefore, your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, and D-400.982 be reaffirmed in lieu of Resolution 215.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.

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6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reform. that adhere to the following principles:

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a. Promote improved patient access to high-quality, cost-effective care.
b. Be designed with input from the physician community.
c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
d. Not require budget neutrality within Medicare Part B.
e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
h. Use adequate risk adjustment methodologies.
i. Incorporate incentives large enough to merit additional investments by physicians.
j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reform. in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

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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.

(56) RESOLUTION 217 - ENSURING PROPORTIONAL ACCOUNTABILITY FOR HOSPITAL EXPENDITURES ATTRIBUTED TO MEDICARE ACOS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-160.915 be reaffirmed in lieu of Resolution 217.

HOD ACTION: Existing AMA policy H-160.915 are reaffirmed in lieu of Resolution 217.

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

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

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

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

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Your Reference Committee heard mixed testimony on Resolution 217, with some testimony supporting adoption, others supporting adoption with amendments, and still others arguing for reaffirmation. The commenters supporting reaffirmation noted that our AMA's Accountable Care Organization Principles, established in existing AMA policy, thoroughly address the concerns raised by Resolution 217.

Your Reference Committee heard additional testimony from the author, who argued that existing policy leaves a specific gap as CMS moves to place more physicians in downside-risk arrangements. The author's concern is that physicians in these arrangements are held financially accountable for hospital expenditures, the largest component of total Medicare spending, despite lacking direct governance authority or operational control over them.

Your Reference Committee appreciates the author's testimony but continues to believe that existing AMA policy thoroughly addresses the concerns raised by Resolution 217. The AMA's Accountable Care Organization Principles, establish that ACOs must be physician-led with governance separate and independent from any hospital governing board, that ACO spending benchmarks be risk-adjusted, that quality and cost methodologies use appropriate attribution consistent with AMA quality reporting principles, and that physicians retain decision-making authority over ACO operations and the distribution of shared savings. These principles directly speak to the concern that physicians should be held accountable only for spending and quality they can control. Therefore, your Reference Committee recommends that existing AMA policy H-160.915 be reaffirmed in lieu of Resolution 217.

Accountable Care Organization Principles H-160.915

Our American Medical Association adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first:
    a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

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b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
d. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the

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program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
8. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
9. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
10. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
11. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
12. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these

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practices to create ACOs and continue to use resources appropriately and efficiently.

13. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
14. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
15. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.
16. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
17. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
18. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

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(57) RESOLUTION 220 - REVERSE CMS CUTS TO FACILITY-BASED PRACTICE EXPENSE PAYMENTS FOR PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, D-400.982, D-330.891, H-385.916, and D-405.965 be reaffirmed in lieu of Resolution 220.

HOD ACTION: Existing AMA policies H-400.972, H-390.849, D-400.982, D-330.891, H-385.916, and D-405.965 are reaffirmed in lieu of Resolution 220.

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

Your Reference Committee received testimony for Resolution 220 that revealed strong opposition to reductions to facility-based practice expenses payment for physicians included in the 2026 Medicare Physician Fee Schedule. While many commenters supported adoption on this basis, others noted that our AMA has extensive and robust Medicare payment policy that encompasses the asks of this resolution, and that our AMA is already actively engaged in advocacy efforts opposing this policy. An example of this work can be seen in the September 2025 comment letter on the 2026 Medicare Physician Fee Schedule proposed rule. Your Reference Committee believes that existing AMA policy is sufficient to allow for advocacy against the specific cuts that are the focus of the resolution alongside broader Medicare payment advocacy efforts. Therefore, your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, and D-400.982, D-330.891, H-385.916, and D-405.965 be reaffirmed in lieu of Resolution 220.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.

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e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
g. The inadequacy of payment for services of assistant surgeons.
h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);

2. Seek an evaluation of:
   a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
   b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare

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geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.

11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reform. that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.

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k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reform. in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

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.

Transparency of Facility Fees for Hospital Outpatient Department Visits D-330.891

1. Our American Medical Association advocates for legislation or regulation that mandates the proactive transparency of the added

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costs to the consumer for health care services rendered at hospital outpatient department designated clinics.

2. Our AMA advocates the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service.

Reimbursement for Office-Based Surgery Facility Fees H-385.916

Our American Medical Association urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities.

Root Cause Analysis of the Causes of the Decline of Private Medical Practice D-405.965

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

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

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(58) RESOLUTION 224 - CLARITY OF SIGNAGE: DISTINGUISHING URGENT CARES FROM EMERGENCY ROOMS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-160.888 be reaffirmed in lieu of Resolution 224.

HOD ACTION: Existing AMA policy H-160.888 are reaffirmed in lieu of Resolution 224.

RESOLVED, that our American Medical Association advocate for federal regulatory or legislative action that would require clear and standardized signage for urgent care centers to distinguish them from hospital emergency departments. (Directive to Take Action)

Your Reference Committee received testimony for Resolution 224 that reflects strong support for the need for clear, standardized signage to distinguish urgent care centers from emergency departments, citing risks of patient confusion, delayed care, and safety concerns. However, multiple commenters, while acknowledging these concerns, argue that existing AMA policy directly addresses the issues raised by Resolution 224. Through this existing policy, our AMA establishes principles that explicitly prohibit urgent care centers from using the word "emergency" or "ED" in their name, advertisements, or descriptions of care, and directs our AMA to support patient education on the differences between urgent care centers and emergency departments.

Your Reference Committee agrees that existing policy directly covers the asks of this resolution. Therefore, your Reference Committee recommends that existing AMA policy H-160.888 be reaffirmed in lieu of Resolution 224.

Urgent Care Centers H-160.888

1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community.
    b. UCCs must transfer a patient's medical records to their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
    c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other

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health care providers in a meaningful format that prominently highlight salient patient information.

d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made.

e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted.

f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers.

g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided.

2. Our AMA will work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.

3. Our AMA supports patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encouraging patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services

(59) RESOLUTION 227 - STANDBY CAPACITY PAYMENTS AND HEALTH IT FOR HOSPITALS IN RURAL AREAS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-290.970, H-290.951, D-305.967, H-480.937, H-478.980, H-350.937, D-478.994, D-478.996, H-465.972, and D-465.998 be reaffirmed in lieu of Resolution 227.

HOD ACTION: Existing AMA policies D-290.970, H-290.951, D-305.967, H-480.937, H-478.980, H-350.937, D-478.994, D-478.996, H-465.972, and D-465.998 are reaffirmed in lieu of Resolution 227.

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RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of H.R. 1, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and be it further

RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 227. Commenters generally agreed on the urgent challenges facing rural health care and highlighted the importance of policies supporting telehealth and other health IT, standby capacity payments for rural providers, and safety net programs. Additional testimony was received that supported amending the resolution, arguing that it should be broadened to encompass more rural health care services, such as emergency care. A few commenters opposed the resolution, arguing that the resolved clauses are unclear or would be difficult to implement. Finally, some comments proposed reaffirmation in lieu of adoption, identifying multiple existing policies for each clause of the resolution that address the issues raised.

Your Reference Committee agrees that the challenges facing rural health care are daunting. However, our AMA already has an extensive body of policy responding to these challenges, including policies that support capacity payments for rural hospitals, increasing access to health IT in rural communities, mitigating cuts to safety net programs that disproportionately impact rural communities, and more.

These policies have enabled strong advocacy on rural issues by our AMA, including endorsing legislation focused on rural issues such as the Rural Residency Planning and Development Act, the Specialty Physicians Advancing Rural Care Act, and the Connected Maternal Online Monitoring Act, and developing maternal health recommendations. Our AMA has also undertaken extensive work in the student loan space in response to H.R. 1 including commenting on House Concurrent Resolution 14, commenting on H.R.1, commenting on the PSLF proposed changes, commenting on the proposed rule surrounding student loan changes, and creating a resource guide to explain the changes in the student loan space. Additionally, as some commenters noted, our AMA has done extensive educational and operational support work on rural issues. In particular, our AMA was very active in shaping state applications for Rural Health Transformation Program (RHTP) funding, and continues to lead on issues relating to the RHTP.

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Therefore, your Reference Committee recommends that existing AMA policies D-290.970, H-290.951, D-305.967, H-480.937, H-478.980, H-350.937, D-478.994, D-478.996, H-465.972, and D-465.998 be reaffirmed in lieu of Resolution 227.

Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts D-290.970

1. Our American Medical Association publicly denounces cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025").
2. Our AMA through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid,
3. Our AMA will continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21.
4. Our AMA will report back to the AMA's House of Delegates at A-26.

Preservation of Medicaid H-290.951

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility.
2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

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4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

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13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in

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terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:

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a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Addressing Equity in Telehealth and Health Technology H-480.937

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an

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emphasis on programs designed with and for historically marginalized and minoritized populations.

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

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Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

Improving Healthcare of Minority Communities in Rural Areas H-350.937

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

Health Information Technology D-478.994

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);

(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;

(3) support initiatives to ensure interoperability among all HIT systems; and

(4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and

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the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

Information Technology Standards and Costs D-478.996

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

Payment Models to Sustain Rural Hospitals H-465.972

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:
    a. support and monitor novel payment models for rural hospitals and encourage uniform reporting; and
    b. 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.

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3. Our AMA will work to vigorously oppose Medicaid cuts as they significantly impact at-risk rural hospitals.

Addressing Payment and Delivery in Rural Hospitals D-465.998

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.
5. Our AMA supports educating patients, physicians, and non-physician practitioners on the impact of Medicare Advantage plans on rural hospitals and encourages all payers to provide adequate payment to support the financial stability of rural hospitals.

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(60) RESOLUTION 231 - PROTECTING AND PROMOTING LONG TERM CARE WORKFORCE AMIDST IMMIGRATION CHALLENGES

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-360.998 and D-255.980 be reaffirmed in lieu of Resolution 231.

HOD ACTION: Resolution 231 is adopted.

RESOLVED, that our American Medical Association oppose administrative or regulatory actions that exacerbate staffing shortages or threaten access to long term care when such actions are not accompanied by adequate workforce supply and training, immigration pathways, and funding support (New HOD Policy); and be it further

RESOLVED, that our AMA support immigration policies that protect, retain, and expand the long-term care workforce, including timely work authorization, efficient visa processing, and protections against abrupt workforce disruptions for immigrant health care workers. (New HOD Policy)

Your Reference Committee heard extensive testimony in support of Resolution 231, with commenters noting that disruptions to the long-term care workforce negatively impacts physicians, patients, and the health care system more broadly. However, additional testimony noted that, while our AMA engages in extensive advocacy efforts relating to easing immigration barriers for physicians and International Medical Graduates (IMGs), the resolution is not physician-focused but addresses immigration barriers faced by nurses, home health aides, and other direct care workers. Reaffirmation of existing policy relating to the workforce shortages was proposed.

Your Reference Committee appreciates that understaffing among nurses, health aides, and other health care workers is a major issue facing our healthcare system. Your Reference Committee recognizes that staffing shortages exist in long-term care and that these important individuals provide life affirming care that is largely non-clinical. In principle, the Committee is aligned with the spirit of the resolution and notes that existing AMA policy states that our AMA will work to “enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions.” The Committee further notes, when feasible, our AMA already undertakes this work. For example. H.R. 7961, which the AMA worked hard to get introduced, would exempt physicians and health care workers involved in direct patient care from the $100,000 H-1B fee. However, the Committee notes that our AMA’s focus in the immigration space must remain on the critical physician shortages that exist across our country and which only our IMG colleagues can ease, as was noted in testimony.

Therefore, your Reference Committee recommends that existing AMA policy D-360.998 and D-255.980 be reaffirmed in lieu of Resolution 231.

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The Growing Nursing Shortage in the United States D-360.998

1. Our American Medical Association recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields.
2. Our AMA encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients.
3. Our AMA encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process.
4. Our AMA will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions.
5. Our AMA will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

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.

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(61) RESOLUTION 234 - PHYSICIAN UNITY IN ADVOCACY REGARDING PHYSICIAN REIMBURSEMENT

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, H-400.972, and H-390.849 be reaffirmed in lieu of Resolution 234.

HOD ACTION: Resolution 234 is referred.

RESOLVED, that our American Medical Association reaffirm that physician payment reform should prioritize the sustainability of the entire physician workforce and the protection of patient access to care (New Hod Policy); and be it further

RESOLVED, that our AMA adopt policy stating that physicians and physician organizations should refrain from advocating for reductions in reimbursement specifically targeted at other physician specialties or physician groups (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician organizations to pursue payment reform through approaches that improve overall fairness, adequacy, and stability of physician reimbursement rather than redistribution among physician specialties (Directive to Take Action); and be it further

RESOLVED, that our AMA affirm that physicians should advocate collectively against reimbursement cuts affecting any group of physicians and support efforts to protect the financial sustainability of all physician practices in order to preserve patient access to care. (New HOD Policy)

Your Refence Committee heard mixed testimony for Resolution 234. Your Reference Committee heard testimony in favor of adopting the resolution, opposing the resolution altogether, amending the resolution, and reaffirming existing policy.

Testimony noted that our AMA has a robust body of Medicare payment policy, is engaged in ongoing, extensive advocacy on Medicare payment issues, and is a leader on Medicare payment reform. Our AMA is already working to unite physicians and bring the House of Delegates together. For example, our AMA's principles for Medicare reform, Characteristics of a Rational Medicare Payment System, have been endorsed by over 70 national medical specialty societies and medical organizations and all 50 state medical associations and the District of Columbia. Additionally, H.R. 8163, the "Provider Reimbursement Stability Act" just unanimously passed a significant Ways and Means markup this month. This important piece of legislation garnered widespread support within the House of Medicine and is a prominent example of the importance of ensuring that our AMA policy benefits the whole House. Though your Reference Committee understands that there are gaps in payment between specialties it also acknowledges the significant and ongoing work within our AMA to minimize payment gaps and to work across all states

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and specialties to ensure that all physicians can thrive. Your Reference Committee notes the significant importance of ensuring that our AMA policy supports the whole House of Medicine and allows our AMA to continue to be an important and neutral convener on this topic.

Given our AMA's unique, central role in ongoing conversations within the House of Medicine regarding Medicare payment reform, your Reference Committee recommends that existing AMA policies D-400.982, H-400.972, and H-390.849 be reaffirmed in lieu of Resolution 234.

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.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.

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b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.

3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs,

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and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.

13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

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2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

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RECOMMENDED FOR FILING

(62) BOARD OF TRUSTEES REPORT 37 - AMA POLICIES ON GENDER AFFIRMING CARE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 37 be filed.

HOD ACTION: Board of Trustees Report 37 is filed.

Your Reference Committee heard substantial testimony regarding Board of Trustees Report 37 and the events that prompted its development. Many commenters expressed concern regarding our AMA's prior public statement on gender affirming care and its consistency with existing AMA policy. At the same time, your Reference Committee heard appreciation for the Board of Trustees' willingness to acknowledge those concerns, provide additional clarification regarding AMA policy, and engage in a transparent discussion with the House of Delegates.

Your Reference Committee appreciates the Board's efforts to summarize our AMA policies that form the foundation of our AMA's position on gender affirming care and to clarify that the prior statement was not intended to alter existing AMA policy. Your Reference Committee also notes the Board's testimony indicating its intent to revise the report, by deletion and addition, on page 3, lines 30-31, and appreciates the Board's responsiveness to concerns raised during testimony regarding that characterization.

Your Reference Committee further heard testimony expressing a desire for continued communication from the Board regarding this matter, including the processes that will be used to ensure future public statements accurately reflect existing AMA policy and receive appropriate expert review prior to release. Given the importance of these issues to physicians and patients, your Reference Committee encourages the Board of Trustees to continue providing updates to the House of Delegates regarding its ongoing work in this area and any further efforts to communicate AMA policy on gender affirming care. Your Reference Committee thanks the Board of Trustees for this informational report and recommends that Board of Trustees Report 37 be adopted as amended.

Your Reference Committee, in concurrence with of the Board of Trustees, notes that the report has been corrected, on page 3, lines 30 through 31, by striking “According to” and all that follows through “the consensus” and inserting “The consensus”. Therefore, your Reference Committee, in accordance with the Board of Trustees, recommends that Board of Trustees Report 37 be filed.

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This concludes the report of Reference Committee B. I would like to thank Elie Azrak, MD, Karl Napekoski, MD, Chris Paprzycki, MD, Sherif Zaafran, MD, Anne Langguth, MD, Matthew Jared, MD, and all those who testified before the Committee.

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Jennifer Hone, M.D.
California
Chair

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DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee C

Alëna Balasanova, MD, DFAPA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
2. Council on Medical Education Report 3 - Support for the Establishment of Indigenous-Led Medical Schools in the United States
3. Council on Medical Education Report 4 - Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States
4. Resolution 302 - Excessive Cost of Multi-State DEA Licensure
5. Resolution 306 - Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
6. Resolution 307 - Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
7. Resolution 308 - Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
8. Resolution 314 - Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
9. Resolution 316 - Addressing Transitions Within GME Regarding Orientation Standards

RECOMMENDED FOR ADOPTION AS AMENDED

10. Resolution 304 - Increasing the Use of Retired Physicians in Teaching Students and Residents
11. Resolution 305 - Leadership by Physicians for Physicians in Graduate Medical Education (GME)
12. *Resolution 310 - Increasing Capacity and Access to Maternal Health Services in Rural Areas
13. Resolution 312 - Advocating for Equitable Application Review in a Single Match System
14. *Resolution 313 - Evaluation of Situational Judgement Tests in Medical School Admissions
15. Resolution 315 - Expanding the Native Hawaiian Health Scholarship Program Eligibility

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RECOMMENDED FOR ADOPTION IN LIEU OF

16. Resolution 309 - Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
17. *Resolution 317 - Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

RECOMMENDED FOR REFERRAL

18. *Council on Medical Education Report 2 - Examining ABMS Processes for New Boards

RECOMMENDED FOR NOT ADOPTION

19. Resolution 303 - Allowing Options for Certification Maintenance
20. Resolution 311 - Changing the Paradigm of Medical Student Debt to Address the Geriatric Physician Shortfall

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

21. Resolution 301 - Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies

**Denotes recommendation has changed from the Preliminary Report (in deposition and/or amended language).*

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RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2016 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 1 be adopted.

HOD ACTION: Council on Medical Education Report 1 is adopted and the remainder of the report filed.

The Council on Medical Education recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee received online testimony in favor of this report and therefore recommends adoption of Council on Medical Education (CME) Report 1.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 3 - SUPPORT FOR THE ESTABLISHMENT OF INDIGENOUS-LED MEDICAL SCHOOLS IN THE UNITED STATES

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 3 be adopted.

HOD ACTION: Council on Medical Education Report 3 is adopted and the remainder of the report filed.

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolves 2 and 4, and the remainder of the report be filed:

1. Our AMA convenes a collaborative with Tribal Nations, Tribal Colleges and Universities (TCUs), Indigenous-led medical education organizations, and academic partners to conduct structured feasibility assessments that lead to the development of Indigenous-led medical schools, including infrastructure needs, accreditation pathways, financing models, and governance structures grounded in tribal sovereignty. (New HOD Policy)

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2. Our AMA advocates for the development and funding of comprehensive mentorship and pathway programs connecting Indigenous pre-medical students with physician and other mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development. (New HOD Policy)

3. Our AMA encourages collaboration between our AMA, medical schools, TCUs, and community organizations to increase pathways and funding for Indigenous students in medicine. (New Policy)

4. Reaffirm AMA policies H-60.917, "Disparities in Public Education as a Crisis in Public Health and Civil Rights," H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," and H-350.960, "Underrepresented Student Access to US Medical Schools." (Reaffirm HOD Policy)

Your Reference Committee received online testimony in favor of this report and therefore recommends adoption of CME Report 3.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 4 - REFLECTING THE VALUES AND PRIORITIES OF TRIBAL COMMUNITIES IN INDIGENOUS-LED MEDICAL SCHOOLS IN THE UNITED STATES

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 4 be adopted.

HOD ACTION: Council on Medical Education Report 4 is adopted and the remainder of the report filed.

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolve 3, and the remainder of the report be filed:

1. Our AMA supports the development of leadership training programs for Indigenous physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, health care administration, and public health. (New HOD policy)

2. Our AMA encourages Indigenous faculty and leadership recruitment/retention through an Indigenous Faculty & Leadership Development Initiative in collaboration with AMA Ed Hub. (New HOD policy)

3. That our AMA develop and disseminate an Indigenous-centered undergraduate medical education curricular resource with collaboration and guidance from tribal communities.(Directive to Take Action)

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4. That our AMA convene an Indigenous Medical Education Design & Partnership Workshop to advance Indigenous educational principles and partnerships. (Directive to Take Action)

5. That our AMA advocate for sustainable funding and workforce policies that support Indigenous learners, faculty, and clinical training partnerships. (New HOD policy)

6. Reaffirm AMA policies H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States" and H-350.960, "Underrepresented Student Access to US Medical Schools." (Reaffirm HOD Policy)

Your Reference Committee received online testimony in favor of this report and therefore recommends adoption of CME Report 4.

(4) RESOLUTION 302 - EXCESSIVE COST OF MULTI-STATE DEA LICENSURE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 302 be adopted.

HOD ACTION: Resolution 302 is adopted.

RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, "One Fee One Number D-100.975" and "One Fee, One Number D-100.980." (Reaffirm HOD Policy)

Your Reference Committee received online testimony in favor of this resolution, which asks for reaffirmation of AMA policies, D-100.975, "One Fee One Number" and D-100.980, "One Fee, One Number". Therefore, your Reference Committee recommends adoption of Resolution 302.

(5) RESOLUTION 306 - COMPETENCY-BASED PORTFOLIO ASSESSMENT OF MEDICAL STUDENTS, INTERNS, RESIDENTS, AND FELLOWS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 306 be adopted.

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HOD ACTION: Resolution 306 is adopted.

RESOLVED, that our American Medical Association amend D-295.318 "Competency-Based Portfolio Assessment of Medical Students" by addition and deletion to read as follows:

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student and trainee evaluations, including competency-based portfolio assessment; and be it further

2. Our AMA will work with the NRMP, ACGME and ~~the 11 schools in the AMA's Accelerating Change in Medical Education consortium~~ medical schools to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency and fellowship match process ~~and off-cycle entry into residency programs,~~ and transitions across the UME-GME practice continuum; including off-cycle entry pathways.
(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" by addition to read as follows:

Our American Medical Association recognizes that implicit biases in evaluations, including those related to gender, race, ethnicity, socioeconomic status, and/or personal background, may influence learner assessment, advancement, and professional opportunities across the medical education continuum;

Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

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An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
    - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
    - Define expected and prohibited behavior.
    - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
    - Ensure privacy and confidentiality to the reporter.
    - Provide a confidential method for documenting and reporting incidents.
    - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
    - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
    - Ideas about the impact of this behavior on themselves and patients.
    - Integrating lessons learned from surveys into programs and policies.

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- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

(Modify Current HOD Policy)

Your Reference Committee received online testimony in favor of this item and therefore recommends adoption of Resolution 306.

(6) RESOLUTION 307 - RECOGNIZING ADVOCACY AS A COMPONENT OF FACULTY APPOINTMENT AND PROMOTION IN ACADEMIC MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 307 be adopted.

HOD ACTION: Resolution 307 is adopted.

RESOLVED, that our American Medical Association reaffirm AMA Policy G-615.103, "Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy" (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA encourage medical education institutions and academic medical centers to recognize physician advocacy activities as a component of faculty appointment, promotion, and tenure criteria (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant organizations representing medical school leadership, to promote best practices for incorporating advocacy efforts into protected non-clinical faculty effort and academic productivity models. (Directive to Take Action)

Your Reference Committee received mixed online testimony. Most testimony supported this resolution, but an amendment was offered regarding states where advocacy is illegal. As most testimony supported adoption and as the language does not describe a requirement but simple encouragement, your Reference Committee recommends that Resolution 307 be adopted.

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(7) RESOLUTION 308 - IMPACT OF FEDERAL AND STATE RESTRICTIVE ACTIONS ON GENDER-AFFIRMING CARE ON MEDICAL EDUCATION AND PHYSICIAN WORKFORCE DEVELOPMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 308 be adopted.

HOD ACTION: Resolution 308 is adopted.

RESOLVED, that our American Medical Association study the impact of federal and state restrictive actions on gender-affirming care on undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), including effects on: (1) clinical training opportunities, (2) accreditation standards and compliance, (3) federal funding streams for medical education and research, (4) faculty recruitment and retention, (5) trainee recruitment, retention, and geographic distribution, (6) academic freedom and curricular integrity, and (7) physician workforce preparedness to provide comprehensive, evidence-based care (Directive to Take Action); and be it further

RESOLVED, that our AMA assess the implications of federal executive actions, agency guidance, regulatory changes, and funding conditions on academic medical centers and training programs that provide or teach gender-affirming care. (Directive to Take Action)

Your Reference Committee received mixed online testimony. Several delegations expressed strong support, while some individuals shared personal opposition to the general subject matter. Since the resolution calls for study and assessment rather than delineating specific practices, your Reference Committee recommends that Resolution 308 be adopted.

(8) RESOLUTION 314 - PROMOTING SEX- AND GENDER-INCLUSIVE DIAGNOSTIC PRACTICES, LANGUAGE, AND PATIENT EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 314 be adopted.

HOD ACTION: Resolution 314 is adopted.

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RESOLVED, that our American Medical Association supports discontinuing use of the term 'atypical' to describe sex- and gender-based differences in symptomatic presentations in medical education curriculum and reference materials. (New HOD Policy)

Your Reference Committee received supportive online testimony. Your Reference Committee agrees and recommends that Resolution 314 be adopted.

(9) RESOLUTION 316 - ADDRESSING TRANSITIONS WITHIN GME REGARDING ORIENTATION STANDARDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 316 be adopted.

HOD ACTION: Resolution 316 is adopted.

RESOLVED, that our American Medical Association study mechanisms for training programs to provide residents and fellows with necessary benefits, including but not limited to health insurance, during transitions in undergraduate and graduate medical education (Directive to Take Action); and be it further

RESOLVED, that our AMA study the benefits of flexible start dates as it relates to reducing logistical and financial burdens on trainees, including but not limited to the following transitions: (1) from medical school to residency; (2) from a transitional or preliminary year to residency; and (3) from residency into fellowship. (Directive to Take Action)

Your Reference Committee received supportive online testimony. Your Reference Committee agrees and recommends that Resolution 316 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(10) RESOLUTION 304 - INCREASING THE USE OF RETIRED PHYSICIANS IN TEACHING STUDENTS AND RESIDENTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association explore, with the appropriate ~~stakeholders~~ interested parties, creative and innovative ways to increase opportunities ~~and decrease hurdles~~ for retired physicians to participate ~~fully~~ as medical faculty at medical schools and residency training programs.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 is adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association explore, with the appropriate interested parties, creative and innovative ways to increase opportunities for retired physicians to participate as medical faculty at medical schools and residency training programs.

RESOLVED, that our American Medical Association explore with the appropriate stakeholders creative and innovative ways to increase opportunities and decrease hurdles for retired physicians to participate fully as medical faculty at medical schools and residency training programs. (Directive to Take Action)

Your Reference Committee received online testimony that was supportive of the intent of Resolution 304. Testimony from the Council on Medical Education offered amendments to delete “decreased hurdles” and “fully,” explaining that it will accomplish the intent while leaving flexibility for implementation of appropriate educators across a broad range of institutions. Another testimony offered a similar amendment. Your Reference Committee agrees with the Council’s amended language, further amended “stakeholders” to modernize language, and recommends that Resolution 304 be adopted as amended.

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(11) RESOLUTION 305 - LEADERSHIP BY PHYSICIANS FOR PHYSICIANS IN GRADUATE MEDICAL EDUCATION (GME)

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 305 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~work with~~ encourage the ACGME to examine ~~and strengthen~~ minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs.

RECOMMNEDATION B:

Your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 is adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association encourage the ACGME to examine minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs.

RESOLVED, that our American Medical Association work with the ACGME to examine and strengthen minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs. (Directive to Take Action)

Your Reference Committee received mixed online testimony. Some testimony was supportive of the resolution as written. The Council on Medical Education offered amendments to improve the factual accuracy and appropriateness of the resolution, which was supported by others. Another testimony offered amendments to “require” that DIOs be physicians, which was supported by others. One testimony suggested referral to better evaluate the rationale, effectiveness, and educational outcomes associated with varying leadership models. Your Reference Committee notes that concerns raised by testimony could be dealt with as part of an examination of the process, and that AMA cannot make requirements for other organizations. Therefore,

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Your Reference Committee recommends that Resolution 305 be adopted as amended.

(12) *RESOLUTION 310 - INCREASING CAPACITY AND ACCESS TO MATERNAL HEALTH SERVICES IN RURAL AREAS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolved clause of Resolution 310 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by ~~evaluating~~ supporting additional ways to increase physicians providing OB-GYN services in shortage areas,~~ including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, and increasing ACGME funding,~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolved clause of Resolution 310 be deleted.

~~RESOLVED, that our AMA support board certification programs that offer family medicine physician training in obstetric care to expand access to maternal health care services in rural areas (New HOD Policy); and be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that the fourth resolved clause of Resolution 310 be amended by deletion to read as follows:

RESOLVED, that our AMA support increased funding ~~and prioritization within the National Health Service Corps Rural Community Loan Repayment Program~~ for ~~OB-GYN and family medicine~~ physicians providing obstetric care ~~working~~ in Maternity Care Target Areas (MCTAs).

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RECOMMENDATION D:

Your Reference Committee recommends that Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 is adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by supporting additional ways to increase physicians providing OB-GYN services in shortage areas; and be it further

RESOLVED, that our AMA support expansion of Family Medicine obstetrical care provided by family physicians who are trained and privileged to deliver such services; and be it further

RESOLVED, that our AMA support increased funding for physicians providing obstetric care in Maternity Care Target Areas (MCTAs).

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by evaluating additional ways to increase physicians providing OB-GYN services in shortage areas, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, and increasing ACGME funding, (Directive to Take Action); and be it further

RESOLVED, that our AMA support board certification programs that offer family medicine physician training in obstetric care to expand access to maternal health care services in rural areas (New HOD Policy); and be it further

RESOLVED, that our AMA support expansion of Family Medicine obstetrical care provided by family physicians who are trained and privileged to deliver such services (New HOD Policy); and be it further

RESOLVED, that our AMA support increased funding and prioritization within the National Health Service Corps Rural Community Loan Repayment Program for OB-GYN and family medicine physicians providing obstetric care working in Maternity Care Target Areas (MCTAs).

Your Reference Committee received supportive online and in-person testimony. Several amendments were offered with the intent of clarifying the language of the resolved clauses. While some in-person testimony was supportive of the recommended amendments in the Preliminary Report, other testimony suggested further amendments. The Council on Medical Education suggested that the first resolved clause be further amended to replace "evaluating" with "supporting" and your

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Reference Committee agrees. Your Reference Committee noted that family medicine (FM) is already a board certifying specialty that allows FM to do obstetrical training, which would deem the second resolved clause unnecessary.

While the Preliminary Report proposed deletion of the fourth resolved clause, in-person testimony sought its inclusion. Concerns were raised about the possible perceived overreach related to NHSC's decision-making as well as unintended consequences. Your Reference Committee appreciates the testimony and offers amended language to the fourth clause in lieu of deletion. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended.

(13) RESOLUTION 312 - ADVOCATING FOR EQUITABLE APPLICATION REVIEW IN A SINGLE MATCH SYSTEM

RECOMMENDATION A:

Your Reference Committee recommends that the first resolved clause of Resolution 312 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~collaborate with its partners to advocate for and ensure~~ support the removal of filters within medical student clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolved clause of Resolution 312 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~collaborate with its partners to advocate for and ensure the removal of all~~ oppose the use of filters within the residency and fellowship application systems which ~~differentiate between~~ denote equivalent aspects such as allopathic and osteopathic degree status (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolved clause of Resolution 312 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within medical student clinical elective application ~~residency and~~

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~~fellowship application~~ systems (Directive to Take Action); and be it further

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 312 be adopted as amended.

HOD ACTION: Resolution 312 is adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association support the removal of filters within medical student clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status; and be it further

RESOLVED, that our AMA oppose the use of filters within the residency and fellowship application systems which denote equivalent aspects such as allopathic and osteopathic degree status; and be it further

RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within medical student clinical elective application systems; and be it further

RESOLVED, that our AMA reaffirm H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students and H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice.

RESOLVED, that our American Medical Association collaborate with its partners to advocate for and ensure the removal of filters within clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with its partners to advocate for and ensure the removal of all filters within the residency and fellowship application systems which differentiate between allopathic and osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within clinical elective application, residency and fellowship application systems (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students and H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice. (Reaffirm HOD Policy)

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Your Reference Committee received supportive online testimony. Your Reference Committee noted that changing the content and filters of application systems is outside the purview of the AMA. Likewise, such data may not be readily available to the AMA to conduct a study as written in the second resolved clause. Your Reference Committee was informed that the online testimony of the Council on Medical Education was intended to contain amendments to the first, second and third resolved clauses that did not carry over in the posting to the ORC. Your Reference Committee appreciates the clarifying amendments from the Council. Thus, your Reference Committee recommends that Resolution 312 be adopted as amended.

(14) RESOLUTION 313 - EVALUATION OF SITUATIONAL JUDGEMENT TESTS IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 313 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~work with~~ support ~~the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other~~ relevant ~~stakeholders~~ interested parties ~~to evaluate~~ in their continued evaluation of the utilization of situational judgment tests, and other similar online decision-making assessments, in ~~the~~ medical school admissions and residency and fellowship selection processes, ~~and~~ to determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 is adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association support relevant interested parties in their continued evaluation of the utilization of situational judgment tests, and other similar online decision-making assessments, in medical school admissions and residency and fellowship selection processes, to determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors.

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RESOLVED, that our American Medical Association work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to evaluate the utilization of situational judgment tests, and other similar online decision-making assessments in the medical school admissions process and determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors. (Directive to Take Action)

Your Reference Committee received supportive online testimony. The Council on Medical Education initially suggested reaffirmation of policies D-310.945 and H-295.844 in lieu of this resolution, but in-person testimony offered amendments to indicate an appropriate scope for AMA's work and to recognize ongoing efforts already being done. One delegation offered an additional amendment to include residents and fellows. All additional testimony was supportive of both amendments and reiterated the importance of research on the impacts of these tests. Your Reference Committee agrees with these amendments and offers minor edits for consistency with AMA language guidelines and the inclusion of residents and fellows. Thus, your Reference Committee recommends that Resolution 313 be adopted as amended.

(15) RESOLUTION 315 - EXPANDING THE NATIVE HAWAIIAN HEALTH SCHOLARSHIP PROGRAM ELIGIBILITY

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 315 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support~~ encourage expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP)~~,~~ or ~~an~~ equivalent program~~s~~ ~~to include Native Hawaiian trainees who provide specialized healthcare services~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 315 be adopted as amended.

HOD ACTION: Resolution 315 is adopted as amended.

Adopted language:

RESOLVED, That our American Medical Association encourage expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP) or equivalent programs.

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RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include Native Hawaiian trainees who provide specialized healthcare services. (New HOD Policy)

Your Reference Committee received supportive online and in-person testimony regarding the need to expand funding and eligibility within the Native Hawaiian Health Scholarship Program (NHHSP) and related programs to address persistent workforce shortages across all specialties. There was also testimony in support of the inclusivity of original resolution language. The Council on Medical Education recommended amendments, noting that NHHSP should retain authority over how its resources are allocated and that its mission already prioritizes areas of greatest need. Testimony noted data highlighting that, of ten recent scholarship recipients, only one was a physician and the others were members of the allied health professions. Your Reference Committee agrees with the favorable testimony and the Council's input. Thus, Your Reference Committee recommends that Resolution 315 be adopted as amended.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(16) RESOLUTION 309 - OSTEOPOROSIS EDUCATION, AWARENESS, AND MUSCULOSKELETAL HEALTH OPTIMIZATION

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 309 be adopted in lieu of original Resolution 309 to read as follows:

RESOLVED, That our American Medical Association encourage development and promotion of physician education, continuing medical education (CME), multidisciplinary programming, research, and patient and physician awareness initiatives regarding osteoporosis and bone health optimization as components of musculoskeletal health, frailty prevention, mobility preservation, healthy aging, surgical risk optimization, and improvement of functional outcomes, including evidence-based strategies related to physical activity, nutrition, fall prevention, screening, and individualized clinical decision-making consistent with existing evidence; and be it further

RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies.

HOD ACTION: Alternate Resolution 309 be adopted in lieu of Original Resolution 309.

Adopted language:

RESOLVED, That our American Medical Association encourage development and promotion of physician education, continuing medical education (CME), multidisciplinary programming, research, and patient and physician awareness initiatives regarding osteoporosis and bone health optimization as components of musculoskeletal health, frailty prevention, mobility preservation, healthy aging, surgical risk optimization, and improvement of functional outcomes, including evidence-based strategies related to physical activity, nutrition, fall prevention, screening, and individualized clinical decision-making consistent with existing evidence; and be it further

RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies.

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RESOLVED, that our American Medical Association study opportunities to enhance physician education regarding osteoporosis as a component of musculoskeletal health, frailty prevention, and surgical risk optimization (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage development or promotion of continuing medical education (CME), educational resources, or multidisciplinary programming highlighting the relevance of bone health to mobility preservation, healthy aging, and surgical outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase patient and physician awareness of evidence-based preventive strategies for osteoporosis including physical activity, nutrition, fall prevention, and appropriate screening consistent with existing recommendations (New HOD Policy); and be it further

RESOLVED, that our AMA encourage research examining the relationship between bone health and outcomes such as frailty, disability, surgical recovery, and health care utilization (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physician education regarding the role of bone health optimization as part of comprehensive strategies to preserve mobility, reduce disability, and improve functional outcomes in aging populations (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician awareness that clinical decision-making regarding osteoporosis screening and treatment may appropriately incorporate individualized risk assessment, including consideration of patients at elevated risk for musculoskeletal deterioration or those being considered for complex spine surgery, consistent with clinical judgment and existing evidence. (New HOD Policy)

Your Reference Committee received mixed testimony for this resolution. The Council on Medical Education supported the intent but was not in favor of the resolution as written and suggested it be streamlined; other testimony concurred. In response, the author submitted alternate language, synthesizing the seven resolved clauses down to two clauses. Your Reference Committee appreciates the new language offered by the author, which addresses the overall intent of the resolution while consolidating language. Your Reference Committee supports the intent of the resolution, noting that this topic is relevant to many specialties. Therefore, your Reference Committee recommends that alternate resolution 309 be adopted in lieu of original resolution 309.

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(17) RESOLUTION 317 - SUPPORT FOR INTERN, RESIDENT, AND FELLOW JEOPARDY PAY AND ADDITIONAL COMPENSATION FOR GAPS IN TRAINEE COVERAGE

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 317 be adopted in lieu of original Resolution 317 to read as follows:

SUPPORT FOR INTERNS, RESIDENTS, AND FELLOWS DURING JEOPARDY CALL VIA IMPACT STUDY

RESOLVED, That our American Medical Association study the impacts of jeopardy duty on resident and fellow trainees, including the frequency and causes of unscheduled coverage, variation across specialties and institutions, and the associated educational, wellness, and workload implications and report back to the House of Delegates with findings and recommendations to inform future policy on systems improvement and, if appropriate, recompense related to jeopardy coverage.

HOD ACTION: Alternate Resolution 317 be adopted in lieu of Original Resolution 317.

Adopted language:

SUPPORT FOR INTERNS, RESIDENTS, AND FELLOWS DURING JEOPARDY CALL VIA IMPACT STUDY

RESOLVED, That our American Medical Association study the impacts of jeopardy duty on resident and fellow trainees, including the frequency and causes of unscheduled coverage, variation across specialties and institutions, and the associated educational, wellness, and workload implications and report back to the House of Delegates with findings and recommendations to inform future policy on systems improvement and, if appropriate, recompense related to jeopardy coverage.

RESOLVED, that our American Medical Association supports standardized compensation (“jeopardy pay”), provided in addition to base salary and benefits, for interns, residents, and fellows who are required to cover unscheduled (“jeopardy”) shifts or additional duties, and encourages programs to adopt transparent and equitable compensation structures that account for specialty-specific burdens. (New HOD Policy)

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Your Reference Committee received mixed testimony that reflected a wide range of perspectives. Testimony from the Council on Medical Education and others opposed the Preliminary Report recommendation of referral due to the specific topic of study and lack of payment data. Testimony emphasized that residents' contributions during jeopardy coverage deserve recognition and that programs should maintain transparent and equitable compensation structures. Several groups supported adoption, noting that existing AMA policy already affirms appropriate compensation for residents and fellows, and expressing concern that further study would be impractical given the significant variation across specialties, institutions, and scheduling models. Testimony in support of referral argued that the underlying issues driving jeopardy coverage, such as specialty-specific burdens, inequitable workload distribution, and structural gaps in scheduling, require deeper examination, particularly due to educational impact not easily alleviated by payment alone. There was also testimony to caution that standardized compensation alone may not resolve these systemic challenges and could create unintended consequences, including incentivizing practices that disrupt education, compromise elective time, or erode professional expectations. There was broad agreement that residents deserve fair treatment and that institutions should not rely on jeopardy coverage in ways that undermine training or leave. However, those who testified differed on whether immediate adoption or further study would best support those goals. Your Reference Committee agrees this is complex issue that warrants deeper assessment of both the underlying factors that contribute to the practice of jeopardy duty and the impacts on trainees to determine the appropriate solution. Therefore, your Reference Committee has changed its recommendation from the Preliminary Report and now recommends alternate Resolution 317 in lieu of original 317 to further study the most appropriate topics related to the issue.

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RECOMMENDED FOR REFERRAL

(18) COUNCIL ON MEDICAL EDUCATION REPORT 2-EXAMINING ABMS PROCESSES FOR NEW BOARDS

RECOMMENDATION:

Your Reference Committee recommends that the second recommendation of Council on Medical Education Report 2 be referred.

HOD ACTION: Council on Medical Education Report 2 be referred.

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 301-A-25, and the remainder of the report be filed:

1. Policy H-275.926,"Medical Specialty Board Certification Standards," item 3b, be amended by deletion to read as follows:
   3b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. ~~In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.~~ (Modify Current HOD Policy)

2. Our AMA supports the following principles to inform the development of new board certifying bodies:
   Principles for New Board Certifying Bodies
   1. Serve the public interest by supporting high-quality evidence-based care, patient safety, professionalism, and ethical conduct of individual physicians.
   2. Maintain independent governance, ensure impartial and transparent processes, engage relevant parties, and uphold fair pathways for transition or reapplication when establishing criteria for certification.
   3. Align certification with recognized education and training, clearly define competencies, and use objective, standards-based assessments that reflect clinical practice.
   4. Incorporate ongoing evaluation and improvement, supported by effective use of technology to enhance accessibility and efficiency.
   5. Ensure representative physician leadership informed by diverse practice settings and provide opportunities for diplomates to participate in governance. (New HOD Policy)

3. Policy D-275.943, "Examining ABMS Processes for New Boards," be rescinded as having been accomplished by this report. (Rescind HOD Policy)

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Your Reference Committee received favorable online and in-person testimony. Several amendments were offered online with the purpose of clarifying the language or intent of the report's recommendations. Your Reference Committee appreciated those suggestions and incorporated language to enhance the new principles outlined in the second recommendation. Testimony addressed whether the recommendations should specify "new" boards versus all boards. Concerns were raised about how some ABMS boards already certify non-physicians appropriately (such as PhDs for medical genetics), as well as if such a change would be germane to the report as currently written. Testimony also suggested that the language regarding the *Essentials for Approval of Examining Boards in Medical Specialties*, as seen in the first recommendation of the report that calls for it to be deleted from Policy H-275.926,"Medical Specialty Board Certification Standards," (clause 3b), should be retained. However, the reason it was deleted is because ABMS changed their bylaws and adopted "Policy on Admission of New Specialty Boards to Membership in ABMS" in 2023 that replaced the *Essentials*. Thus, your Reference Committee concurs that deletion is appropriate.

The Council on Medical Education testified that the proposed new sixth clause of the Principles that addressed only physicians, as seen in the Preliminary Report, be referred. However, it was determined that the new clause itself does not stand alone and therefore cannot be handled as such. Thus, your Reference Committee recommends that entire CME 2 be referred back to the Council to revise their report to elucidate the concerns raised in testimony.

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RECOMMENDED FOR NOT ADOPTION

(19) RESOLUTION 303 - ALLOWING OPTIONS FOR CERTIFICATION MAINTENANCE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 303 be not adopted.

HOD ACTION: Resolution 303 is not adopted.

RESOLVED, that our American Medical Association encourage all hospitals and insurance programs in the United States to end the monopoly of MOC and accept NBPAS to accomplish any MOC requirements (New HOD Policy); and be it further

RESOLVED, that our AMA request that the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA) accept this alternative route for MOC for all teachers of medical students and physicians in order to maintain quality and experienced instruction in residency programs and medical schools in this era of physician shortages. (Directive to Take Action)

Your Reference Committee received online and in-person testimony that was primarily opposed to Resolution 303. One testimony offered amendments, and another suggested that policies be reaffirmed in lieu of this resolution. The author testified in support of the resolution and proposed additional amendments. Others acknowledged support of the spirit of the resolution but not the language nor amendments. Your Reference Committee recognizes frustrations related to the current process, including one state's ongoing actions which disadvantage physicians in ways that are opposed to existing AMA policies, such as H-275.924, "Continuing Board Certification". Your Reference Committee also notes extensive testimony that ongoing work is already taking place to remedy these issues, including the elimination of high-stakes exams from multiple boards. Most in-person testimony also emphasized that the original resolution as well as amendments may create unintended consequences, such as confusion among the public regarding physician qualifications, or may jeopardize the board certification process. Your Reference Committee concurs with the concerns raised in opposing testimony and recommends that Resolution 303 be not adopted.

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(20) RESOLUTION 311 - CHANGING THE PARADIGM OF MEDICAL STUDENT DEBT TO ADDRESS THE GERIATRIC PHYSICIAN SHORTFALL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 311 be not adopted.

HOD ACTION: Resolution 311 is not adopted.

RESOLVED, that our American Medical Association (AMA) develop a platform supporting a 3-year medical school curriculum in order to help reduce medical student debt and reduce the coming physician shortage (Directive to Take Action); and be it further

RESOLVED, that our AMA, in order to advance equity in the medical profession, work to ensure all specialties—especially primary care—can compete fairly, reduce the looming physician shortage especially those providing care to older patients (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the AAMC and Liaison Committee on Medical Education (LCME) begin steps to ensure that all medical schools offer a 3-year program by 2030 to help reduce student debt. (Directive to Take Action)

Your Reference Committee received mixed online testimony. Several testimonies noted opposition due to the lack of evidence that mandating of shortened medical school would solve the issues the resolution seeks to address. One testimony raised concern about unintended consequences, such that compressing medical school to 3 years could possibly reduce exposure to specialties (e.g., ophthalmology). The Council on Medical Education noted that the AMA has already invested in initiatives such as ChangeMedEd®, which examines innovations in medical education, including the role and utility of accelerated three-year pathways. The Council further noted that AMA already maintains extensive policy supporting and strengthening the primary care workforce. Your Reference Committee agrees that it is not feasible or appropriate to encourage all medical schools to transition to a three-year curriculum, particularly within such a limited time-frame, and concurs with concerns regarding the actionability and specificity of the language. Thus, your Reference Committee recommends that Resolution 311 be not adopted.

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(21) RESOLUTION 301 - EXPANDING RESIDENT AND FELLOW EXPOSURE TO DIVERSE HEALTHCARE PRACTICE MODELS TO FULFILL ACGME CORE COMPETENCIES

RECOMMENDATION:

Your Reference Committee recommends that Policy H-295.864 be reaffirmed in lieu of Resolution 301.

HOD ACTION: Policy H-295.864 be reaffirmed in lieu of Resolution 301.

RESOLVED, that our American Medical Association will advocate to the ACGME and other relevant accrediting and educational bodies for the formal inclusion and recognition of diverse practice model exposure as a vital component of Systems-Based Practice training. (Directive to Take Action)

Your Reference Committee received mixed online testimony. One testimony suggested reaffirmation of Policy H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians", in lieu of this resolution. The author concurred with reaffirmation. Another testimony offered amended language. Your Reference Committee agrees with reaffirmation to achieve the resolution's goal of continuing to support systems-based practice education through close engagement with the ACGME. Thus, Your Reference Committees recommends that Policy H-295.864 be reaffirmed in lieu of this resolution.

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a

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physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

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This concludes the report of Reference Committee C. I would like to thank Robert Dunn, MD, Holly Rosencranz, MD, Emma Vomer, DO, David Whalen, MD, Barbara Weissman, MD, Jocelyn Young, DO, and all those who testified before the Committee. I would also like to thank AMA staff persons Lena Drake, Dave Henderson, MD, Kim Lomis, MD, Tanya Lopez, and Amber Ryan.

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American College of Emergency Physicians

David Whalen, MD
Michigan State Medical Society

Holly Rosencranz, MD
Illinois State Medical Society

Barbara Weissman, MD
California Medical Association

Emma Vomer, DO
American Academy of Family Physicians

Jocelyn Young, DO
Medical Society of the State of New York

Alëna Balasanova, MD, DFAPA
American Academy of Addiction Psychiatry
Chair

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DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee D

Cheryl Hurd, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT 17 - Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
2. BOT 29 - Educational Materials Regarding Ultra-processed Foods
3. CSAPH 01 - Council on Science and Public Health Sunset Review of 2016 House Policies
4. CSAPH 03 – Public Health Implications of Food Subsidies
5. CSAPH 04 - Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
6. CSAPH 05 - Removing Artificial Turf in Schools, Parks, and Public Places
7. CSAPH 10 - Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation
8. Resolution 404 - Develop Climate-Conscious Resources for Physicians
9. Resolution 411 - Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
10. Resolution 413 - Erosion of the Public Evidence Base for Health Policy
11. Resolution 415 - Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
12. Resolution 416 - Clinical Laboratory Workforce Shortage and Sustainability
13. Resolution 421 - Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
14. Resolution 422 - Expanding Access to High Resolution Anoscopy
15. Resolution 423 - Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
16. Resolution 424 - Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
17. Resolution 429 - Adolescent Dating Violence Comprehensive Screening Tool Development
18. Resolution 430 - Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
19. Resolution 433 - Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment
20. Resolution 435 - Supporting Regulations for More Stringent Safety Measures for Micromobility
21. Resolution 437 - Addressing Housing Needs of the Native Hawaiian and their Diaspora

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RECOMMENDED FOR ADOPTION AS AMENDED

22. CSAPH 02 - Setting Standards for Forensic Toxicology Laboratories Used in Litigation
23. CSAPH 06 - Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
24. Resolution 401 - Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
25. Resolution 402 - Strengthening Public Health Protections Against Raw Milk–Associated Illness
26. Resolution 403 - AMA's continued support for COVID-19 vaccination in pregnant individuals and children
27. Resolution 405 - Studying the Environmental Impact of Ambient Clinical Intelligence Use
28. Resolution 407 - Colorectal Cancer in Alaskan Native Patients
29. Resolution 408 - Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
30. Resolution 409 - Eliminate PFAS and Glyphosate in our Food and Environment
31. Resolution 414 - Restoring Balanced Scientific Perspective within the ACIP
32. Resolution 417 - Respiratory Protection for Wildland Firefighters
33. Resolution 418 - Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
34. Resolution 419 - Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
35. Resolution 420 - Expanding Support for Women Experiencing Homelessness
36. Resolution 425 - Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
37. Resolution 426 - Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")
38. Resolution 427 - Infant Feeding Options for HIV-Seropositive Individuals
39. Resolution 428 - Protecting Environmental Health Before, During, and After War
40. Resolution 431 - Supporting Transportation Infrastructure Reform for Public Health
41. Resolution 432 - Addressing Public Health Risks of Online Sports Betting
42. Resolution 436 - Protecting Children from Potential Harms of Caffeinated Products
43. Resolution 439 - Age Verification and ENDS Products

RECOMMENDED FOR ADOPTION IN LIEU OF

44. Resolution 438 - Preserving and Strengthening Maternal Mortality Review Committees

RECOMMENDED FOR REFERRAL

45. Resolution 406 - Reduce Environmental Impact of Medical Journals
46. Resolution 412 - Guiding Principles of Pandemic Prevention, Preparedness and Response; Support for the World Health Organization Pandemic Agreement
47. BOT 09 – American Medical Association Optimal Health Outcomes Report

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RECOMMENDED FOR REFERRAL FOR DECISION

48. Resolution 410 - Light Pollution

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

49. Resolution 434 - Vaccinations in Physician Offices

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RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES (BOT) 17 - SUPPORTING THE INTEGRATION OF BLOOD PRESSURE VARIABILITY DATA IN ELECTRONIC MEDICAL RECORDS REPORT

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Board of Trustees (BOT) Report 17 be adopted and the remainder of the report be filed.

HOD ACTION: BOT Report 17 be adopted and the remainder of the Report filed.

The Board of Trustees recommends that Resolution 424-A-25 be amended by addition and the remainder of the report be filed.

That our AMA support additional research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers; and be it further (New HOD Policy)

That our American Medical Association support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index once additional research has been published on this topic, including peer-reviewed evidence establishing clinical utility, reproducibility of blood pressure variability metrics, and such research has informed recommendations or guidance from relevant clinical and public health authorities. (New HOD Policy)

Your Reference Committee heard limited, but unanimously supportive testimony on the recommendations presented in this report. Hypertension remains one of the leading contributors to cardiovascular disease, stroke, renal disease, and maternal morbidity and mortality in our nation. Emerging evidence demonstrates that blood pressure variability may provide additional important insight and should be integrated into electronic medical records once additional research establishes clinical utility and has informed clinical guidance. Therefore, your Reference Committee recommends adoption.

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(2) BOARD OF TRUSTEES 29 - EDUCATIONAL MATERIALS REGARDING ULTRA-PROCESSED FOODS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in BOT Report 29 be adopted and the remainder of the report be filed.

HOD ACTION: BOT Report 29 be adopted and the remainder of the Report filed.

ADOPTED LANGUAGE:
Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods"
1. Our AMA supports and promotes awareness and education, among both the public and clinicians, about the differences between healthy and unhealthy ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.
3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.
4. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.
5. Our AMA supports increased funding for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks. (Modify Current HOD Policy)

The Board of Trustees recommends:

(1) That the second resolve of Resolution 601-A-25 not be adopted; and

(2) That Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods" be amended by addition and deletion to read as follows:

1. Our AMA supports and promotes ~~public~~ awareness and education, among both the public and clinicians, about the differences between healthy~~ful~~ and unhealthy~~ful~~ ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.
~~2.~~ 3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.

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~~3.~~ 4. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.
~~4.~~ 5. Our AMA supports increased funding ~~to the FDA~~ for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Your Reference Committee heard supportive testimony for this report, which was developed in response to Resolution 601-A-25 which sought to conduct further study on the health impact of ultraprocessed foods (UPF) and develop multilingual patient educational materials to disseminate information about the harmful health effects of UPFs. The report findings highlighted a need for a standardized definition of UPFs and therefore led the BOT to recommend that the second resolve of Resolution 601-A-25 not be adopted. This received supportive testimony in agreement. The remainder of the report recommended that current policy H-150.914 be amended to support education and awareness about the health impacts of UPFs. This received multiple comments of support, with one delegation noting that our AMA should consider more opportunities to gain visibility via the dissemination of educational materials to physicians and the public. Your Reference Committee agrees, and therefore, recommends adoption of the recommendations in BOT Report 29.

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(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH (CSAPH) 01 - COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2016 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in CSAPH Report 01 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 01 be adopted and the remainder of the Report filed.

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Testimony on the recommended actions within this report was limited. Two amendments were proposed by an individual to help clarify language within policies. CSAPH noted that the actions taken within a sunset report are limited and they are careful not to make amendments that could potentially change the intent or meaning of the policy. CSAPH believes these proposed amendments are outside of the purview of the sunset report. Your Reference Committee agrees and therefore, recommends adoption.

(4) CSAPH 03 – PUBLIC HEALTH IMPLICATIONS OF FOOD SUBSIDIES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in CSAPH Report 03 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 03 be adopted and the remainder of the Report filed.

ADOPTED LANGUAGE:
Policy H-150.932, "Reform the US Farm Bill to Improve US Public Health and Food Sustainability"

Our American Medical Association will advocate for:

- **Increased subsidies for the production of a diversity of health-promoting, whole foods, including fruits and vegetables;**
- **Reallocation of existing subsidies to improve equity for farmers that have been historically excluded from or underfunded by federal agricultural assistance programs;**
- **Increased funding for financial incentives, programs, and research initiatives to support sustainable agricultural practices, restorative agriculture, conservation efforts, and other projects that improve ecological diversity and resilience to climate change;**

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- **Strengthen funding for U.S. Farm Bill initiatives which incorporate a 'food is medicine' approach and support interventions such as medically tailored meals, produce prescriptions, medically tailored groceries, nutrition counseling, and evidence-based education on preparation of healthy food; and**
- **the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Modify Current HOD Policy)**

The Council on Science and Public Health recommends that AMA Policy H-150.932, "Reform the US Farm Bill to Improve US Public Health and Food Sustainability," be amended by addition and deletion to read as follows and the remainder of the report be filed.

~~Reform the US Farm Bill to Improve US Public Health and Food Sustainability:~~ Our American Medical Association will advocate for ~~supports~~:

- Increased subsidies for the production of a diversity of health-promoting, whole foods, including fruits and vegetables;
- Reallocation of existing subsidies to improve equity for farmers that have been historically excluded from or underfunded by federal agricultural assistance programs;
- Increased funding for financial incentives, programs, and research initiatives to support sustainable agricultural practices, restorative agriculture, conservation efforts, and other projects that improve ecological diversity and resilience to climate change;
- Strengthen funding for U.S. Farm Bill initiatives which incorporate a 'food is medicine' approach and support interventions such as medically tailored meals, produce prescriptions, medically tailored groceries, nutrition counseling, and evidence-based education on preparation of healthy food; and
- the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Modify Current HOD Policy)

Your Reference Committee heard unanimously supportive testimony for this report from multiple delegations and sections. Testimony noted the importance of supporting sustainable, affordable, and healthy food systems, which is directly and indirectly impacted through U.S. food subsidies. Testimony also supported the inclusion and advancement of a "food is medicine" approach with the U.S. Farm Bill. Your Reference Committee recommends that the recommendation in CSAPH Report 03 be adopted.

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(5) CSAPH 04 - IMPROVING PUBLIC AWARENESS OF LUNG CANCER SCREENING AND CAD IN CHRONIC SMOKERS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in CSAPH Report 04 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 04 be adopted and the remainder of the Report filed.

ADOPTED LANGUAGE:
Policy H-185.936 "Lung Cancer Screening to be Considered Standard Care"

1. **Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.**
2. **Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.**
3. **Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.**
4. **Our AMA, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR), will create and share educational resources and training to help physicians efficiently discuss and document low-dose computed tomography (LDCT) lung cancer screening during shared decision-making visits for high-risk populations.**
5. **Our AMA will promote physician education and awareness regarding the value of low-dose CT in detecting lung cancer, and will encourage education, technological innovation, and continued research around the detection of coronary artery calcification on low-dose CT performed as a part of a lung cancer screening program.**
6. **Our AMA will support efforts by key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to research interventions to improve access to and utilization of lung cancer screening with low-dose CT scans in high-risk patients. (Modify Current HOD Policy)**

Your Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 404-A-25 and the remainder of the report be filed.

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That Policy H-185.936 "Lung Cancer Screening to be Considered Standard Care," be amended by addition to read as follows:

1. Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.
2. Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
3. Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.
4. Our AMA, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR), will create and share educational resources and training to help physicians efficiently discuss and document low-dose computed tomography (LDCT) lung cancer screening during shared decision-making visits for high-risk populations.
5. Our AMA will promote physician education and awareness regarding the value of low-dose CT in detecting lung cancer, and will encourage education, technological innovation, and continued research around the detection of coronary artery calcification on low-dose CT performed as a part of a lung cancer screening program.
6. Our AMA will support efforts by key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to research interventions to improve access to and utilization of lung cancer screening with low-dose CT scans in high-risk patients. (Modify Current HOD Policy)

Your Reference Committee heard very supportive testimony for this report. Testimony noted the gaps in lung cancer screening rates, especially among high-risk patients. Testimony overwhelmingly supported efforts to promote physician education and advocacy for low-dose CT screening. Therefore, your Reference Committee recommends that the recommendation in CSAPH Report 04 be adopted.

(6) CSAPH 05 - REMOVING ARTIFICIAL TURF IN SCHOOLS, PARKS, AND PUBLIC PLACES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in CSAPH Report 05 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 05 be adopted and the remainder of the Report filed.

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The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 408-A-25, and the remainder of the report be filed.

1. The American Medical Association (AMA) recommends well maintained, natural, drought-tolerant and hardiness zone appropriate turfgrass, with the use of integrated pest management to reduce potential chemical exposures, as the preferred choice on sports fields or lawns, in public and private schools and colleges, as well as in city parks.
2. Our AMA recommends municipalities conduct comprehensive risk-benefit analyses when deciding whether to replace natural turfgrass with artificial turf (or vice versa) to best meet the needs and concerns of their communities, including those with accessibility concerns.
3. The AMA encourages more research to address evidence gaps on the potential health risks of artificial turf fields. In particular, more research is needed on the release of chemicals from artificial turf, the level of exposure to turf users, and potential health impacts, as well as the differences in risk from heat-related illnesses and physical injuries on artificial turf versus natural turf. (New HOD Policy)

Your Reference Committee heard unanimously supportive testimony for this report from multiple delegations and sections, including the authoring delegation of the original resolution from A-25 which was referred for study. Testimony highlighted that the report takes a balanced and evidence-based approach to this topic while also weighing accessibility concerns that are critical to ensure artificial or natural turf fields are usable for all. Your Reference Committee recommends that the recommendations in CSAPH Report 05 be adopted.

(7) CSAPH 10 - STANDARDIZING SAFETY REQUIREMENTS FOR TRADITIONAL AND RIDESHARE BASED NON-EMERGENCY MEDICAL TRANSPORTATION

RECOMMENDATION:

Your Reference Committee recommends that that the Recommendations in CSAPH Report 10 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 10 be adopted and the remainder of the Report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. Our AMA acknowledges that transportation is a foundational component of health care access and supports policies that ensure vulnerable populations can obtain necessary medical care.
2. Our AMA supports efforts to promote greater consistency and coordination in the minimum safety standards that guide traditional nonemergency medical transportation across states and delivery models and encourages ongoing evaluation of these standards as transportation systems and patient needs evolve.

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3. Our AMA acknowledges that rideshare based nonemergency medical transportation (RB-NEMT) is an expanding component of medical transportation and supports continued research to assess safety risks and establish evidence-based minimum safety requirements to help ensure RB-NEMT can be integrated safely and appropriately into patient care. (New HOD Policy)

Your Reference Committee heard testimony that was largely supportive of this report and its recommendations. Multiple delegations, sections, and individuals highlighted the growing role of rideshare-based non-emergency medical transportation (RB-NEMT) as an innovative approach to improving access, while underscoring the need for consistent safety standards, oversight, and evidence-based guidance as these models expand. Two delegations raised concerns regarding the limited attention to specific populations, particularly children, with one delegation recommending referral to ensure this population was addressed. The Council on Science and Public Health noted that the report contemplated different population needs at a high level and noted that exploring different populations in detail was beyond the scope of this report, given that the ask of the original resolution was broad and not specific to children. Given the overall support for this report, and the Council's rationale that population-specific considerations may be more appropriately addressed in future work, your Reference Committee recommends that the recommendations in CSAPH Report 10 be adopted.

(8) RESOLUTION 404 - DEVELOP CLIMATE-CONSCIOUS RESOURCES FOR PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 404 be adopted.

HOD ACTION: Resolution 404 be adopted.

RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions; and be it further

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems; and be it further

RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities; and be it further

RESOLVED, that our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability.

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Your Reference Committee heard unanimously supportive testimony for this resolution. Testimony noted this resolution aligns and complements existing AMA policy on climate change and that AMA is well positioned to disseminate resources and tools to physicians and health systems on ways to reduce the environmental footprint of healthcare. Your Reference Committee recommends adoption of Resolution 404.

(9) RESOLUTION 411 - ADDRESSING THE MYOPIA EPIDEMIC, PUBLIC EDUCATION, AND INSURANCE COVERAGE FOR EVIDENCE-BASED MYOPIA CONTROL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 411 be adopted.

HOD ACTION: Resolution 411 be adopted.

RESOLVED, that our American Medical Association recognize that myopia is a significant and increasing public health concern warranting public health outreach, improved screening in children, and prevention efforts; and be it further

RESOLVED, that our AMA advocate for public education initiatives to increase awareness among patients, caregivers, educators, and policymakers about the risks of progressive myopia and the availability of evidence-based interventions shown to slow myopia progression; and be it further

RESOLVED, that our AMA support efforts to formally classify myopia as a disease, including by CMS, to ensure that patients can receive appropriate treatment and insurance coverage for the treatment of this medical condition; and be it further

RESOLVED, that our AMA support efforts to ensure comprehensive insurance coverage and reimbursement for evidence-based treatments demonstrated to slow myopia progression in pediatric and adolescent patients.

Your Reference Committee heard unanimously supportive testimony for this resolution. Many delegations and sections noted the urgency of the proposed policy due to increasing rates of myopia across the globe, and the severe consequences of untreated myopia. Therefore, your Reference Committee recommends that Resolution 411 be adopted.

(10) RESOLUTION 413 - EROSION OF THE PUBLIC EVIDENCE BASE FOR HEALTH POLICY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 413 be adopted.

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HOD ACTION: Resolution 413 be adopted.

RESOLVED, that our American Medical Association urges the U.S. federal government to publicly disclose the causes of federal disease surveillance interruptions; to provide expeditious timelines for restoration of surveillance databases and analyses for all nationally notifiable diseases, including hiring and re-hiring of scientifically qualified and appropriately funded staff; and to adopt an adequate mandatory public notification protocol for any future pauses; and be it further

RESOLVED, that our AMA advocate Congressional oversight, including an annual report, assessing CDC surveillance performance; staffing adequacy; data transparency; and the impact of funding levels collectively on public health readiness and national security.

Your Reference Committee heard testimony that was unanimously supportive of Resolution 413. Multiple delegations, sections, and individuals emphasized the critical importance of robust, transparent, and well-funded public health surveillance systems, noting that timely and accurate data are essential for clinical decision-making and effective public health response. Testimony also highlighted concerns regarding recent interruptions and lack of transparency in federal surveillance systems, as well as the need for adequate staffing, funding, and Congressional oversight to ensure reliability and accountability. Therefore, your Reference Committee recommends that Resolution 413 be adopted.

(11) RESOLUTION 415 - ADVOCACY FOR RESTORATION OF THE ENDANGERMENT FINDING REGARDING GREENHOUSE GAS EMISSIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 415 be adopted.

HOD ACTION: Resolution 415 be adopted.

RESOLVED, That our AMA encourage the Litigation Center to monitor lawsuits against the rescinding of the endangerment finding and to consider submitting amicus curiae briefs in those with a likelihood of success on behalf of the HOD; and be it further

RESOLVED, that our AMA advocate against the repeal of the endangerment finding and support its restoration; and be it further

RESOLVED, that our AMA publicly state that repeal of the endangerment finding is a threat to public health and take appropriate action, to include collaboration with relevant associations and stakeholders, to ensure that the public is adequately educated.

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Your Reference Committee heard unanimously supportive testimony from multiple delegations and individuals for this resolution. Testimony reinforced the urgency of regulation and action on reducing greenhouse gas emissions that are causing climate change which has a myriad of adverse health impacts. Additionally, those testifying noted that the restoration of the endangerment finding is a critical policy lever to reduce greenhouse gas emissions and protect public health. Your Reference Committee recommends adoption of Resolution 415.

(12) RESOLUTION 416 - CLINICAL LABORATORY WORKFORCE SHORTAGE AND SUSTAINABILITY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 416 be adopted.

HOD ACTION: Resolution 416 be adopted.

RESOLVED, that our American Medical Association recognize the unique and critical role of medical laboratory professionals in patient care and public health and the urgent need to address workforce shortages; and be it further

RESOLVED, that our AMA support advocacy efforts to sustain and strengthen clinical laboratory training and education programs, including assistance for faculty development and infrastructure, to address capacity and recruitment needs; and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, educational institutions, health care organizations, and professional societies, to promote awareness of clinical laboratory careers, as members of the physician-led health care team, among students and the public.

Your Reference Committee heard testimony that was strongly supportive of the original language in Resolution 416. Multiple delegations, sections, and individuals emphasized the critical role of medical laboratory professionals in patient care, noting that workforce shortages are contributing to delays in diagnostic testing, strain on existing staff, and challenges in maintaining timely, high-quality care across clinical settings. An amendment was proposed by a delegation to expand the resolution's focus to include competency-based educational pathways and evaluation of unnecessary barriers to workforce entry. Multiple delegations and sections had concerns with this amendment noting that it could have unintended consequences. Your Reference Committee agrees and therefore recommends that Resolution 416 be adopted.

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(13) RESOLUTION 421 - IMPROVING ACCESS TO CARE AND SUPPORT FOR PATIENTS WITH INFLAMMATORY BOWEL DISEASE IN THE UNITED STATES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 421 be adopted.

HOD ACTION: Resolution 421 be adopted.

RESOLVED, That the American Medical Association (AMA) support the development and implementation of standardized, scalable referral and patient navigation pathways for each state — through collaboration with the American Gastroenterological Association, the American College of Gastroenterology, the American Society for Gastrointestinal Endoscopy, the Crohn's & Colitis Foundation, state and local Departments of Public Health, Federally Qualified Health Centers, safety-net health systems, and community-based organizations — to connect patients with inflammatory bowel disease to timely and affordable colonoscopy services for diagnosis and surveillance, leveraging existing colorectal cancer screening and navigation models (New HOD Policy); and be it further

RESOLVED, That the AMA support educational initiatives and resource dissemination, developed in collaboration with appropriate partners—including patient advocacy organizations, professional societies, and health systems—to increase awareness among physicians regarding documentation requirements for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) eligibility in patients with severe inflammatory bowel disease, in order to improve access to financial support and insurance coverage (New HOD Policy); and be it further

RESOLVED, That the AMA support policies that support nationwide efforts to expand equitable access to colonoscopy services for patients with inflammatory bowel disease and increase physician awareness of disability benefit eligibility as a mechanism to improve continuity of care and access to necessary medical services (New HOD Policy).

Your Reference Committee heard limited testimony that was unanimously supportive of this resolution. Multiple delegations and sections emphasized the importance of improving access to timely, coordinated diagnostic and specialty care for patients with inflammatory bowel disease, highlighting persistent barriers including delays in colonoscopy, fragmented care, and insurance-related challenges. Testimony also underscored the critical role of colonoscopy and longitudinal monitoring in preventing complications and reducing disparities, as well as the value of collaborative approaches to improve care delivery. Therefore, your Reference Committee recommends that Resolution 421 be adopted.

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(14) RESOLUTION 422 - EXPANDING ACCESS TO HIGH RESOLUTION ANOSCOPY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 422 be adopted.

HOD ACTION: Resolution 422 be adopted.

RESOLVED, that our AMA collaborate with relevant national medical specialty societies to promote development and dissemination of evidence-based and practical guidance, referral pathways, and implementation strategies to integrate anal cancer screening and HRA access into routine care for high-risk populations; and be it further

RESOLVED, that our AMA encourage and promote educational resources, training opportunities, and competency guidance related to high-resolution anoscopy developed by relevant medical specialty societies and other expert organizations in order to support expansion of patient access and an appropriately trained workforce; and be it further

RESOLVED, that our American Medical Association advocate at the federal and state levels for policies that expand equitable access to high-resolution anoscopy (HRA) for high-risk populations, including ensuring adequate reimbursement, reducing geographic disparities, and supporting workforce development; and be it further

RESOLVED, that our AMA encourage federal agencies, including the Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS), to support funding mechanisms and demonstration programs that expand HRA capacity in HIV care settings, federally qualified health centers, and underserved communities.

Your Reference Committee heard unanimously supportive testimony for this resolution. Multiple delegations and sections remarked that real-world implementation of anal cancer screening lags and noted an urgent need for further training and equipment to incorporate screening into routine care. In particular, it was noted that high-risk populations, who would benefit the most from screening, are often unable to access high resolution anoscopy due to workforce shortages, geographic disparities, and inadequate reimbursement. Multiple sections testified that patients are forced to travel far distances to access evidence-based care, and that this resolution identifies gaps to reduce existing health disparities. Therefore, your Reference Committee recommends that Resolution 422 be adopted.

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(15) RESOLUTION 423 - EXPANDING ACCESS TO HIV PRE-EXPOSURE PROPHYLAXIS (PREP)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 423 be adopted.

HOD ACTION: Resolution 423 be adopted.

RESOLVED, that our AMA supports advocacy, research funding, and targeted programmatic support to address disparities in PrEP access among populations disproportionately affected by HIV, ensuring that strategies are tailored to the unique needs of these communities; and be it further

RESOLVED, that our AMA supports efforts to expand PrEP access to all individuals in alignment with evidence-based guidelines and shared decision making, including but not limited to innovative delivery models across various care settings and strategies to address social determinants of health that impede PrEP uptake such as housing instability, transportation barriers, and stigma.

Your Reference Committee heard testimony that was unanimously supportive of Resolution 423. Multiple delegations, sections, and individuals emphasized the importance of expanding access to HIV pre-exposure prophylaxis (PrEP) and highlighted ongoing challenges to uptake, particularly among populations disproportionately impacted by HIV. An amendment was proffered to explicitly include youth in the first Resolve clause. The authors noted that maintaining broader language, without specifying a particular age or group, will allow the AMA to advocate for all populations and adapt as access needs evolve. Your Reference Committee agrees and therefore recommends that Resolution 423 be adopted.

(16) RESOLUTION 424 - SUPPORTING EDUCATION AND ACCESS TO POSTEXPOSURE DOXYCYCLINE (DOXYPEP)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 424 be adopted.

HOD ACTION: Resolution 424 be adopted.

RESOLVED, that our AMA supports physician and trainee education on Postexposure Doxycycline (DoxyPEP) and other anti-microbial postexposure treatments; and be it further

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RESOLVED, that our AMA supports prescribing and insurance coverage of Postexposure Doxycycline (DoxyPEP) for sexually transmitted infection (STI) prevention.

Your Reference Committee heard testimony that was unanimously supportive of Resolution 424. Multiple delegations, sections, and individuals emphasized the effectiveness of doxycycline postexposure prophylaxis (DoxyPEP) as an emerging strategy to prevent bacterial sexually transmitted infections and highlighted persistent gaps in awareness, access, and uptake. An amendment was proffered to add language specifying "for all ages" in the first Resolve clause. The authors noted that the existing language is intentionally broad and inclusive and that adding qualifiers may unnecessarily limit the flexibility of the policy. Your Reference Committee agrees and therefore recommends that Resolution 424 be adopted.

(17) RESOLUTION 429 - ADOLESCENT DATING VIOLENCE COMPREHENSIVE SCREENING TOOL DEVELOPMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 429 be adopted.

HOD ACTION: Resolution 429 be adopted.

RESOLVED, that our American Medical Association ask relevant stakeholders, including federal agencies, academic institutions, and professional societies, to support the development of validated, culturally sensitive, LGBTQ+ inclusive adolescent-specific screening tools for adolescent intimate partner violence that can be easily implemented in the clinic setting.

Your Reference Committee heard unanimously supportive testimony for this resolution. Multiple delegations and sections emphasized the risks of adolescent dating violence, particularly among female and LGBTQ+ students. Testimony noted the need for adolescent specific screening tools, especially for those most at risk, and that current AMA policy does not sufficiently cover the development of culturally sensitive and adolescent specific tools to prevent violence. Your Reference Committee agrees and therefore recommends that Resolution 429 be adopted.

(18) RESOLUTION 430 - SUPPORT HEAVY METAL AND TOXIC EXPOSURE TESTING FOR RESIDENTS AFFECTED BY WILDFIRES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 430 be adopted.

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HOD ACTION: Resolution 430 be adopted.

RESOLVED, that our American Medical Association supports the development, dissemination, and implementation of voluntary post-wildfire toxicant exposure screening protocols, covering heavy metals, polycyclic aromatic hydrocarbons (PAHs), and other dangerous air pollutants and toxic substances, for wildfire-impacted individuals and communities, in coordination with appropriate public health and environmental agencies, universities, public health schools and societies; and be it further

RESOLVED, that our AMA support federal and state efforts, in partnership with public health and environmental agencies, to ensure access to environmental monitoring, mobile health services, medical follow-up, and treatment for individuals exposed to toxic substances during or after wildfire events, with particular attention to frontline, vulnerable and disproportionately impacted communities.

Your Reference Committee heard generally supportive testimony for this resolution from multiple sections although one delegation and one individual testified in support of referral. Supportive testimony noted that wildfires are becoming increasingly more frequent, intense, and destructive leading to widespread exposure to hazardous air pollution and threatening public health. Testimony in support of referral felt that further study is needed to develop specific actionable recommendations around testing for heavy metals and that if individuals were screened for heavy metals and found to be positive for exposure, there would be no specific treatment and therefore screening would have limited utility. The resolution authors testified in opposition to referral, noting that the resolution does not mandate universal screening, it doesn't prescribe rigid testing protocols independent of evidence-based guidance, and screening is still valuable in that it can identify exposure patterns and affected populations that can be targeted for public health interventions or further follow-up. Due to the largely supportive testimony for Resolution 430, your Reference Committee recommends adoption.

(19) RESOLUTION 433 - ADDRESSING THE EPIDEMIC OF FRAGILITY FRACTURES THROUGH IMPROVED OSTEOPOROSIS SCREENING AND TREATMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 433 be adopted.

HOD ACTION: Resolution 433 be adopted.

RESOLVED, that our American Medical Association recognize fragility fractures and untreated osteoporosis as a significant and urgent public health issue in the United States; and be it further

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RESOLVED, that our AMA support expanded and evidence-based osteoporosis screening efforts, including improved access to dual-energy X-ray absorptiometry scanning and Fracture Risk Assessment Tool evaluations for at-risk populations; and be it further

RESOLVED, that our AMA encourage health systems, hospitals, and physician groups to develop and implement coordinated fracture liaison services and secondary fracture prevention programs; and be it further

RESOLVED, that our AMA advocate for legislation or regulation for improved insurance coverage and payment policies for osteoporosis screening, diagnosis, pharmacologic treatment, and follow-up care; and be it further

RESOLVED, that our AMA support nationwide public and physician education initiatives aimed at increasing awareness of osteoporosis risk factors, prevention, and the importance of post-fracture evaluation.

Your Reference Committee heard testimony that was largely supportive of Resolution 433. Multiple delegations and sections emphasized that osteoporosis and fragility fractures remain underdiagnosed and undertreated, highlighting significant gaps in screening, treatment, and secondary fracture prevention despite the availability of effective interventions. A delegation proffered an amendment to strike the first Resolve clause, noting concern regarding the characterization of osteoporosis as a public health issue. An individual proffered an amendment to strike the third Resolve noting concern about the feasibility and implementation of coordinated fracture liaison services. Given that there was no testimony in support of these amendments and that the majority of the testimony was in support of this resolution including support for the content the proffered amendments sought to delete, your Reference Committee recommends that Resolution 433 be adopted.

(20) RESOLUTION 435 - SUPPORTING REGULATIONS FOR MORE STRINGENT SAFETY MEASURES FOR MICROMOBILITY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 435 be <u>adopted</u>.

HOD ACTION: Resolution 435 be <u>adopted</u>.

RESOLVED, that our American Medical Association better define and expand AMA policy to help improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the following positions:
1. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
2. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;

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3. Headphones should be avoided during use;
4. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;
5. Require education and training for Class 3 e-bikes;
6. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
7. No distractions while operating;
8. No passengers while operating;
9. Regulate out-of-class products and anti-tampering;
10. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules; (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association encourage and advocate for accelerated research into the root causes of e-bike and e-scooter related injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof (Directive to take Action).

Your Reference Committee heard limited but supportive testimony for this resolution. This resolution addresses the growing public health risks associated with e-bikes and e-scooters by promoting clear safety standards, rider education, and responsible use as well as the need for improved injury surveillance and research to better understand and prevent micromobility-related injuries. Therefore, your Reference Committee recommends that Resolution 435 be adopted.

(21) RESOLUTION 437 - ADDRESSING HOUSING NEEDS OF THE NATIVE HAWAIIAN AND THEIR DIASPORA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 437 be <u>adopted</u>.

HOD ACTION: Resolution 437 be <u>adopted</u>.

RESOLVED, that our American Medical Association support federal funding for housing programs, including efforts by the Department of Hawaiian Home Lands (DHHL), that prioritizes tribal self-determination for Indigenous communities and inclusion of Native Hawaiians regardless of geographic location; and be it further

RESOLVED, that our American Medical Association recognize Native Hawaiian Organizations as the authoritative bodies for determining Native Hawaiian membership and lineage, and oppose the use of externally imposed criteria, such as blood quantum, to determine eligibility for any form of federal, state, or local assistance.

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Your Reference Committee heard brief but unanimously supportive testimony for this resolution, which highlighted the severe impact of homelessness on native Hawaiian populations. Testimony underscored the urgent nature of the resolution, with state budgets receiving drastic reductions and an increasing number of legal challenges to indigenous Hawaiian self-governance. Testimony also emphasized the gravity of homelessness in Hawaii, which currently has the highest rates of homelessness in the United States. Your Reference Committee agrees and therefore recommends that Resolution 437 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(22) CSAPH 02 - SETTING STANDARDS FOR FORENSIC TOXICOLOGY LABORATORIES USED IN LITIGATION

RECOMMENDATION A:

Your Reference Committee recommends the first Recommendation of CSAPH Report 02 be amended by deletion to read as follows:

1. **Our American Medical Association support national efforts to establish a unified, science-based oversight framework for CLIA-exempt ~~forensic~~ toxicology laboratories, including the development of consistent baseline standards, a coordinated national accreditation structure, enhanced transparency requirements, and complementary oversight expectations for individual CLIA-exempt ~~forensic~~ toxicology laboratories ~~practitioners~~ to address the absence of mandatory accreditation and the current fragmentation of quality systems; and**

RECOMMENDATION B:

Your Reference Committee recommends that the second Recommendation in the CSAPH Report 02 be amended by deletion to read as follows:

2. **Our American Medical Association encourages greater transparency in CLIA-exempt ~~forensic~~ toxicology laboratory operations, including publicly accessible information on personnel qualifications, accreditation status and scope, quality assurance practices, method validation documentation, and scientific oversight processes, and the key evidentiary materials needed for judicial evaluation such as raw data, validation records, quality-control logs, and proficiency testing results, to strengthen the reliability, interpretability, and accountability of ~~medicolegal~~ testing. (Directives to Take Action)**

RECOMMENDATION C:

Your Reference Committee recommends that the Recommendations in CSAPH Report 02 be adopted as amended and the remainder of the report be filed.

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RECOMMENDATION D:

Your Reference Committee recommends that the title of CSAPH Report 02 be changed to read as follows:

SETTING STANDARDS FOR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-EXEMPT TOXICOLOGY LABORATORIES USED IN LITIGATION

HOD ACTION: CSAPH Report 2 adopted as amended and remainder of Report filed.

ADOPTED LANGUAGE:
Setting Standards for Clinical Laboratory Improvement Amendments (CLIA)-Exempt Toxicology Laboratories Used in Litigation

1. Our American Medical Association support national efforts to establish a unified, science-based oversight framework for CLIA-exempt toxicology laboratories, including the development of consistent baseline standards, a coordinated national accreditation structure, enhanced transparency requirements, and complementary oversight expectations for individual CLIA-exempt toxicology laboratories to address the absence of mandatory accreditation and the current fragmentation of quality systems; and
2. Our American Medical Association encourages greater transparency in CLIA-exempt toxicology laboratory operations, including publicly accessible information on personnel qualifications, accreditation status and scope, quality assurance practices, method validation documentation, and scientific oversight processes, and the key evidentiary materials needed for judicial evaluation such as raw data, validation records, quality-control logs, and proficiency testing results, to strengthen the reliability, interpretability, and accountability of testing. (Directives to Take Action)

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. Our American Medical Association support national efforts to establish a unified, science-based oversight framework for CLIA-exempt forensic toxicology laboratories, including the development of consistent baseline standards, a coordinated national accreditation structure, enhanced transparency requirements, and complementary oversight expectations for individual forensic toxicology practitioners to address the absence of mandatory accreditation and the current fragmentation of quality systems; and
2. Our American Medical Association encourages greater transparency in forensic toxicology laboratory operations, including publicly accessible information on personnel qualifications, accreditation status and scope, quality assurance practices, method validation documentation, and scientific oversight processes, and the key evidentiary materials needed for judicial evaluation such as raw data, validation records, quality-control logs, and proficiency testing results, to strengthen the reliability, interpretability, and accountability of medicolegal testing. (Directives to Take Action)

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Your Reference Committee heard mixed testimony that was generally supportive of the report and its recommendations. Testimony in support emphasized the importance of establishing a more consistent, science-based oversight framework for toxicology laboratories, noting variability in current practices, gaps in standardization, and the implications for both civil and criminal proceedings. An amendment was proffered, asking to reinstate provisions related to laboratory leadership qualifications. The Council on Science and Public Health opposed the proposed amendment, expressing concern that specifying personnel requirements could unnecessarily limit flexibility and narrow the pool of qualified leadership. This amendment was also opposed by multiple delegations. A delegation proffered an amendment to remove reference of "forensic" in the recommendations as well as "medicolegal" stating that the inclusion of forensic would include postmortem toxicology services which have well-established and rigorous standards already in place. They noted that specifically referencing CLIA-exempt toxicology laboratories would be in line with the intent of the report, while also recognizing and respecting the distinct role of postmortem toxicology systems. Multiple delegations were in support of this amendment including the original author of the resolution. Your Reference Committee agrees with this amendment and therefore recommends that the recommendations in CSAPH Report 02 be adopted as amended.

(23) CSAPH 06 - MITIGATING AIR AND NOISE POLLUTION FROM AVIATION IN MINORITY COMMUNITIES DISPROPORTIONATELY IMPACTED AND VULNERABLE COMMUNITIES

RECOMMENDATION A:

Your Reference Committee recommends the first Recommendation of CSAPH Report 06 be amended by addition and deletion to read as follows:

1. **Supports increased surveillance, monitoring and research of air and noise pollution exposure from aviation, specifically for ~~vulnerable populations,~~ airport workers and persons who reside in neighborhoods near airports or under flight paths ~~nearby communities~~.**

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in the CSAPH Report 06 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CSAPH Report 6 adopted as amended and remainder of Report filed

ADOPTED LANGUAGE:
Our American Medical Association:

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1. Supports increased surveillance, monitoring and research of air and noise pollution exposure from aviation, specifically for airport workers and persons who reside in neighborhoods near airports or under flight paths.
2. Encourages studies on the effectiveness of different interventions to mitigate air and noise pollution exposure from aviation.
3. Encourages airports to implement policy measures identified under the 'balanced approach' system to minimize noise exposure in surrounding communities, which could include changes to common flight paths, flight curfews, land use planning and community engagement, sound-proof insulation projects in nearby communities, and further technological advances to reduce jet engine noise.
4. Supports the phase-in of sustainable aviation fuels to reduce air pollution and climate impacts associated with aviation. (New HOD Policy)

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 421-A-25, and the remainder of the report be filed.

Our American Medical Association:

1. Supports increased surveillance, monitoring and research of air and noise pollution exposure from aviation, specifically for vulnerable populations, airport workers and nearby communities.
2. Encourages studies on the effectiveness of different interventions to mitigate air and noise pollution exposure from aviation.
3. Encourages airports to implement policy measures identified under the 'balanced approach' system to minimize noise exposure in surrounding communities, which could include changes to common flight paths, flight curfews, land use planning and community engagement, sound-proof insulation projects in nearby communities, and further technological advances to reduce jet engine noise.
4. Supports the phase-in of sustainable aviation fuels to reduce air pollution and climate impacts associated with aviation. (New HOD Policy)

Your Reference Committee heard limited but overwhelmingly supportive testimony for this report and for its recommendations. Testimony highlighted that aviation pollution disproportionately impacts marginalized communities and the need for a more sustainable transportation system. One individual proffered a friendly amendment to provide more specific context for which populations are most vulnerable to aviation pollution, namely those who reside in neighborhoods near airports. There was no objection to this suggested amendment by the report's authors, and your Reference Committee agrees this helps clarify and strengthen the recommendations. Therefore, your Reference Committee recommends the adoption of CSAPH Report 06 recommendations as amended.

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(24) RESOLUTION 401 - PARTNERSHIP WITH THE ADMINISTRATION TO REDUCE HARMFUL CHEMICALS IN FOOD AND ALIGN WITH EUROPEAN SAFETY STANDARDS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, independent academic scientists, and relevant administration appointees to:

1) **Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in other nations ~~Europe~~**
2) **Evaluate the scientific evidence regarding health impacts of these substances**
3) **Develop a prioritized timeline for regulatory action on the most concerning additives**
4) **Create transition pathways for food manufacturers to adopt safer alternatives (Directive to Take Action); and be it further**

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 401 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 401 be changed to read as follows:

PARTNERSHIP WITH THE ADMINISTRATION TO REDUCE HARMFUL CHEMICALS IN FOOD

HOD ACTION: Resolution 401 be adopted as amended.

ADOPTED LANGUAGE:
Partnership with the Administration to Reduce Harmful Chemicals in Food

RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials,

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USDA personnel, independent academic scientists, and relevant administration appointees to:

1) **Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in other nations**
2) **Evaluate the scientific evidence regarding health impacts of these substances**
3) **Develop a prioritized timeline for regulatory action on the most concerning additives**
4) **Create transition pathways for food manufacturers to adopt safer alternatives (Directive to Take Action).**

RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements (Directive to Take Action).

RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, and relevant administration appointees to:
1. Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in Europe
2. Evaluate the scientific evidence regarding health impacts of these substances
3. Develop a prioritized timeline for regulatory action on the most concerning additives
4. Create transition pathways for food manufacturers to adopt safer alternatives (Directive to Take Action); and be it further

RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony from multiple groups for this resolution, citing the importance of reducing harmful chemical exposures in our food supply and advancing evidence-based policies that protect public health from these exposures. A friendly amendment was proffered to add 'independent academic scientists' to the groups that would be asked to engage in this joint task force, and this amendment was supported by the resolution authors. Additionally, one delegation expressed concern about the reference to Europe specifically within the first Resolve, noting that there may be other nations outside of Europe or other important public health bodies that have created guidance or regulations on food additives (e.g., the World Health Organization). Your Reference Committee felt this was an important point and amended the first bullet in the first Resolve to be broader in scope while maintaining the spirit of the resolution. Another concern was raised about the fiscal impact of monitoring regulations around food additives. As monitoring regulations and policies are within the normal scope of activities of AMA advocacy staff, we did not feel this point needed to be addressed through additional amendments to the resolution. During in-person testimony, an amendment was offered by FDA to delete the entire first Resolve clause noting that there are existing efforts underway within the FDA to address safety concerns over food additives. Your Reference Committee did not hear any additional testimony in opposition to its preliminary report

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recommendation. The resolution author was not supportive of FDA proffered amendments and CSAPH testified noting that they are working on a report on food additives for the Interim 2026 meeting and the issues brought up during testimony could be considered within that report. Therefore, your Reference Committee recommends Resolution 401 be adopted as amended and the title be changed to be aligned with the amended text.

(25) RESOLUTION 402 - STRENGTHENING PUBLIC HEALTH PROTECTIONS AGAINST RAW MILK–ASSOCIATED ILLNESS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 402 be amended by addition to read as follows:

RESOLVED, that our American Medical Association oppose the consumption, sale, and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve clause of Resolution 402 be amended by addition to read as follows:

RESOLVED, that our AMA collaborate with like-minded organization, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw, unpasteurized milk and dairy products for children and those who are pregnant, targeting parents, schools, and childcare providers (Directive to Take Action), and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the fourth Resolve clause of Resolution 402 be amended by addition to read as follows:

RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for general public and for members of vulnerable

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populations, including children and those who are pregnant; (Directive to Take Action); and be it further

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 402 be adopted as amended.

HOD ACTION: Resolution 402 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association oppose the consumption, sale, and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications (New HOD Policy).

RESOLVED, that our AMA urge congress and state legislatures to prohibit interstate sale of raw unpasteurized milk, strengthening current FDA regulation.

RESOLVED, that our AMA collaborate with like-minded organization, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw, unpasteurized milk and dairy products for children and those who are pregnant, targeting parents, schools, and childcare providers (Directive to Take Action).

RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for the general public and for members of vulnerable populations, including children and those who are pregnant; (Directive to Take Action).

RESOLVED, that our AMA support banning raw milk in settings accessible to children, such as schools and daycare facilities.

RESOLVED, that our American Medical Association oppose the consumption and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications; and be it further

RESOLVED, that our AMA urge congress and state legislatures to prohibit interstate sale of raw unpasteurized milk, strengthening current FDA regulation; and be it further

RESOLVED, that our AMA collaborate with like-minded organizations, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw, unpasteurized milk and dairy products for children, targeting parents, schools, and childcare providers; and be it further

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RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for general public and for members of vulnerable populations; and be it further

RESOLVED, that our AMA support banning raw milk in settings accessible to children, such as schools and daycare facilities.

Your Reference Committee heard supportive testimony from multiple delegations and individual physicians regarding the urgent need for this resolution. Testimony noted that while the public health benefits of pasteurization and health risks of consuming raw milk have been well documented for some time, there has been a growing movement of support for the consumption and deregulation of raw milk. Consuming raw milk can cause severe illness and disease, especially for immuno-compromised individuals. Despite strong support for the resolution, there were a few suggested amendments. The first suggestion was to amend the first Resolve to say 'sale' versus 'consumption,' which was supported by some but not others, noting that the AMA should oppose consumption, sale and distribution of raw milk. Additionally, another delegation suggested adding language to Resolve clauses three and four to include specific references to children and pregnant individuals as vulnerable populations that should not consume raw milk. Considering that others who testified also mentioned these groups as vulnerable populations, your Reference Committee believes these amendments to be valuable. Your Reference Committee recommends that Resolution 402 be adopted as amended.

(26) RESOLUTION 403 - AMA'S CONTINUED SUPPORT FOR COVID-19 VACCINATION IN PREGNANT INDIVIDUALS AND CHILDREN

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 403 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore ~~explicit~~ <u>evidence-based vaccine</u> recommendations, <u>including</u> for COVID-19 vaccination of pregnant individuals and ~~young~~ children aged 6 months to 17 years. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 403 be <u>adopted as amended</u>.

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HOD ACTION: Resolution 403 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore evidence-based vaccine recommendations, including for COVID-19 vaccination of pregnant individuals and children aged 6 months to 17 years. (Directive to Take Action)

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore explicit recommendations for COVID 19 vaccination of pregnant individuals and young children aged 6 months to 17 years.

Your Reference Committee heard testimony that was supportive of Resolution 403. Multiple delegations, sections, and individuals emphasized the importance of maintaining evidence-based COVID-19 vaccination recommendations, particularly for pregnant individuals and children, and highlighted the continued risk of severe outcomes in these populations. Several amendments were proffered during testimony, highlighting the challenge of calling for restoring explicit recommendations rather than calling for evidence-based vaccine recommendation, with recognition that science may change over time. An additional amendment called for removing the word "young." These amendments received support from multiple delegations and individuals. An individual also proposed additional resolve clauses to emphasize patient counseling and shared decision-making, as well as to support appropriate reimbursement and resources for these discussions; however, there was no additional testimony in support of these proposals. Therefore, your Reference Committee recommends that Resolution 403 be adopted as amended.

(27) RESOLUTION 405 - STUDYING THE ENVIRONMENTAL IMPACT OF AMBIENT CLINICAL INTELLIGENCE USE

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve clause of Resolution 405 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support efforts to require ~~voluntarily~~ reporting of emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 405 be adopted as amended.

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HOD ACTION: Resolution 405 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action).

RESOLVED, that our AMA support efforts to require reporting of emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy).

RESOLVED, our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action).

RESOLVED, our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware. (Directive to Take Action)

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to voluntarily report emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RESOLVED, our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action); and be it further

RESOLVED, our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony for this resolution with one delegation offering an amendment to the second Resolve clause to change voluntary reporting of emissions, water usage, and waste to mandatory. Since changing the word voluntary to mandatory did not make sense grammatically, your Reference Committee felt amending that Resolve with the word “require” instead of “mandatory” fulfilled the spirit of the requested amendment. Other testimony noted that while there are benefits of AI integration in health care, the rapid and large-scale development of AI data centers across the U.S has raised important environmental and public health concerns, including strain on electrical grids and water resources. It was noted that EPA has jurisdiction over this

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issue and should be noted but no amendment was submitted. Your Reference Committee recommends Resolution 405 be adopted as amended.

(28) RESOLUTION 407 - COLORECTAL CANCER IN ALASKAN NATIVE PATIENTS

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve clause of Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will coordinate with interested national medical specialty societies, state medical associations, ~~Alaska Native Corporations~~ tribal health organizations, the Indian Health Service, and tribal governments to enhance physician education and awareness of the tribal public health authority recommendation to initiate preventive screening for colorectal cancer at age 40 in individuals with Alaska Native ancestry and advocate that these screenings be covered by all public and private payers, including the Indian Health Service and U.S. Centers for Medicare and Medicaid Services. These patients should also be counseled that the U.S. Preventive Services Task Force does not have a position on initiating colorectal cancer screening at age 40 in the Alaska Native population, and thus should be presented the risks and benefits associated with colonoscopy and medically appropriate screening alternatives. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 407 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 407 be changed to read as follows:

COLORECTAL CANCER IN ALASKA NATIVE PATIENTS

HOD ACTION: Resolution 407 be adopted as amended.

ADOPTED LANGUAGE:
Colorectal Cancer in Alaska Native Patients

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RESOLVED, that our American Medical Association advocates that the National Cancer Institute dedicate resources to the investigation of early-onset colorectal cancer in Americans younger than age 45.

RESOLVED, that our AMA will coordinate with interested national medical specialty societies, state medical associations, tribal health organizations, the Indian Health Service, and tribal governments to enhance physician education and awareness of the tribal public health authority recommendation to initiate preventive screening for colorectal cancer at age 40 in individuals with Alaska Native ancestry and advocate that these screenings be covered by all public and private payers, including the Indian Health Service and U.S. Centers for Medicare and Medicaid Services. These patients should also be counseled that the U.S. Preventive Services Task Force does not have a position on initiating colorectal cancer screening at age 40 in the Alaska Native population, and thus should be presented the risks and benefits associated with colonoscopy and medically appropriate screening alternatives. (Directive to Take Action)

RESOLVED, that our American Medical Association advocates that the National Cancer Institute dedicate resources to the investigation of early-onset colorectal cancer in Americans younger than age 45; and be it further

RESOLVED, that our AMA will coordinate with interested national medical specialty societies, state medical associations, Alaska Native Corporations, and tribal governments to enhance physician education and awareness of the tribal public health authority recommendation to initiate preventive screening for colorectal cancer at age 40 in individuals with Alaska Native ancestry and advocate that these screenings be covered by all public and private payers, including the Indian Health Service and U.S. Centers for Medicare and Medicaid Services. These patients should also be counseled that the U.S. Preventive Services Task Force does not have a position on initiating colorectal cancer screening at age 40 in the Alaska Native population, and thus should be presented the risks and benefits associated with colonoscopy and medically appropriate screening alternatives.

Your Reference Committee heard mixed testimony regarding Resolution 407. Multiple delegations, sections, and individuals expressed strong support for addressing colorectal cancer disparities among Alaska Native populations, emphasizing the significantly elevated incidence rates, earlier onset of disease, and the importance of tailoring screening and preventive strategies based on population-specific epidemiologic risk. However, a delegation and an individual raised concerns regarding the focus on a single population and the absence of population-specific recommendations from the U.S. Preventive Services Task Force, and supported referral for further study to better assess evidence, cost-effectiveness, and broader applicability to other populations. A delegation proffered an amendment to ensure accurate mention of organizations to coordinate with. The authors were in support of this amendment. A section proffered an amendment to ensure inclusion of appropriate screening alternatives such as CT colonography. Multiple delegations, sections, and an individual opposed this amendment, noting that referencing specific modalities is unnecessary and that the existing language “and medically appropriate screening alternatives” already addresses the intent. Your Reference

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Committee agrees with these recommendations. In addition, your Reference Committee notes that the proper terminology is Alaska Native, not Alaskan Native, and further recommends a title change to address this concern and therefore, recommends that Resolution 407 be adopted as amended.

(29) RESOLUTION 408 - ADDRESSING RURAL MATERNAL MORBIDITY AND MORTALITY THROUGH COLLABORATION AND INTERSECTIONALITY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 408 be amended by addition to read as follows:

RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, the effects of changes in Medicaid reimbursement, expansion and extension for maternity care, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve clause of Resolution 408 be amended by addition to read as follows:

RESOLVED, that our AMA collaborate with specialty societies, academic medical institutions, and public health stakeholders to promote and disseminate innovative practice models, such as regional call-sharing systems, tele-maternal-fetal medicine support, and hospital–physician partnership structures-designed to reduce rural maternal morbidity and mortality, including during the postpartum period. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 408 be adopted as amended.

HOD ACTION: Resolution 408 be adopted as amended.

ADOPTED LANGUAGE:

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RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, the effects of changes in Medicaid reimbursement, expansion and extension for maternity care, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period.

RESOLVED, that our AMA ensure that this report includes evidence-based recommendations to reduce preventable maternal mortality through the postpartum year, including strategies for optimized allocation of federal and state funding.

RESOLVED, that our AMA collaborate with specialty societies, academic medical institutions, and public health stakeholders to promote and disseminate innovative practice models, such as regional call-sharing systems, tele-maternal-fetal medicine support, and hospital–physician partnership structures- designed to reduce rural maternal morbidity and mortality, including during the postpartum period. (Directive to Take Action)

RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period; and be it further

RESOLVED, that our AMA ensure that this report includes evidence-based recommendations to reduce preventable maternal mortality through the postpartum year, including strategies for optimized allocation of federal and state funding; and be it further

RESOLVED, that our AMA collaborate with specialty societies and public health stakeholders to promote and disseminate innovative practice models—such as regional call-sharing systems, tele–maternal-fetal medicine support, and hospital–physician partnership structures—designed to reduce rural maternal morbidity and mortality, including during the postpartum period.

Your Reference Committee heard mostly supportive testimony for this resolution with a few amendments proffered and one delegation requesting referral of the second resolve. Only one individual supported reaffirmation of existing AMA policy as proposed by AMA staff. Supportive testimony highlighted the importance of this resolution to address the growing maternal health crisis affecting rural communities and praised that it covered the postpartum period as a critical window for maternal health. Suggested amendments proposed adding Medicaid changes to the scope of the proposed study and academic medical institutions as one of the AMA collaborators. Your Reference Committee heard supportive testimony for at least one of these amendments and felt both were valuable additions. The delegation requesting referral of the second resolve noted that while they supported the development of evidence-based recommendations they felt this resolve text would benefit from more careful consideration. Since this resolution is already calling on the AMA to study this issue and referral of the second resolve would result in a study by our AMA, your Reference Committee did not feel that it was necessary to refer the second

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resolve as evidence-based recommendations will be produced through the resulting study. As such, your Reference Committee recommends the adoption of Resolution 408 as amended.

(30) RESOLUTION 409 - ELIMINATE PFAS AND GLYPHOSATE IN OUR FOOD AND ENVIRONMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 409 be amended by addition to read as follows:

RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating to ~~the EPA, USDA, FDA,~~ relevant regulatory bodies and ~~other~~ stakeholders for ~~removal~~ reduction of PFAS and ~~G~~glyphosate chemicals from our food supply and environment to concentrations below which there have been no observed adverse effects demonstrated~~, while preserving access to FDA-approved medically necessary drugs and devices, including metered-dose and propellent-driven inhalers, where clinically appropriate alternatives are not available~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 409 be amended by addition of a second Resolve clause to read as follows:

RESOLVED, that our American Medical Association oppose the use of PFAS-containing insecticides in industrial agriculture.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 409 be adopted as amended.

HOD ACTION: Resolution 409 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating to relevant regulatory bodies and stakeholders for reduction of PFAS and glyphosate chemicals from our food supply and environment to concentrations below which there have been no observed adverse effects demonstrated.

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RESOLVED, that our American Medical Association oppose the use of PFAS-containing insecticides in industrial agriculture.

RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating for removal of PFAS and Glyphosate chemicals from our food supply and environment.

Your Reference Committee heard mostly supportive testimony for this resolution from multiple delegations, sections and individuals. However, there was concern noted by several testifying that the resolution as written was not practical or achievable, as the chemicals mentioned in the resolution are so pervasive in our environment and the evidence is still evolving on how they impact health. The resolution authors testified during the in-person hearing that they preferred the more aspirational language of the original resolution text, noting that safe levels for these chemicals are unknown and that many of these chemicals are long-lasting and accumulate over time within our bodies and in the environment. Opposition to the preliminary report recommendations and support for the original resolution language was supported by others during the in-person hearing. Additionally, amendments were proffered to include the agencies that our AMA would be advocating to and make sure that inhalers, some of which use PFAS chemicals as propellants, should not be impacted by other regulatory actions to reduce these chemicals. Your Reference Committee was supportive of these amendments but wanted to ensure that the policy could be used broadly for advocacy purposes and therefore included 'other stakeholders' with the proposed amendments. Your Reference Committee recommends Resolution 409 be adopted as amended.

(31) RESOLUTION 414 - RESTORING BALANCED SCIENTIFIC PERSPECTIVE WITHIN THE ACIP

RECOMMENDATION A:

Your Reference Committee recommends <u>the second Resolve clause</u> of Resolution 414 be <u>amended by addition</u> to read as follows:

RESOLVED, that our AMA condemns the arbitrary and unilateral <u>April</u> 2026 alterations to the ACIP charter, which appear to have been designed to subvert the authority of relevant Federal judges and to allow the appointment of unqualified committee members and liaisons to the Advisory Committee on Immunization Practices (ACIP)

RECOMMENDATION B:

Your Reference Committee recommends <u>the fourth Resolve clause</u> of Resolution 414 be <u>amended by addition and deletion</u> to read as follows:

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RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the ~~most recent~~ April 2026 update of the charter.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 414 be amended by addition of a fifth Resolve clause to read as follows:

RESOLVED, That our AMA immediately oppose any executive order or federal administrative action that changes or proposes to change the United States vaccine schedules without proper evidence and scientific review by an appropriately convened Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) per the approved charter prior to June 2025.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 414 be amended by addition of a sixth Resolve clause to read as follows:

RESOLVED, That our AMA oppose any alignment of the United States vaccine schedules with other international recommendations that do not strictly account for unique U.S. domestic data and demographics.

RECOMMENDATION E:

Your Reference Committee recommends Resolution 414 be adopted as amended.

HOD ACTION: Resolution 414 be adopted as amended.

ADOPTED LANGUAGE:
Policy D-440.902, Advisory Committee on Immunization Practices
1. Our American Medical Association will continue sustained public advocacy in support of the previous Advisory Committee on Immunization Practices (ACIP) structure, including the liaison representative program, as outlined in ACIP's 2024 Charter and practiced until Spring 2025.
2. Our AMA pursue all appropriate channels to reverse the 2025-2026 changes to ACIP's structure, membership, and operations.

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3. Our AMA request an investigation into the actions of the U.S. Secretary of Health and Human Services regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.
4. Our AMA will continue to identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary; and be it further

RESOLVED, that our AMA condemns the arbitrary and unilateral April 2026 alterations to the ACIP charter, which appear to have been designed to subvert the authority of relevant Federal judges and to allow the appointment of unqualified committee members and liaisons to the Advisory Committee on Immunization Practices (ACIP).

RESOLVED, that our AMA will collaborate with interested state and specialty societies to support litigation against changes to the ACIP charter, budget, operating principles and staffing which produce ongoing harm to the public's health, and many of which were adopted without adequate and meaningful opportunity for public comment;

RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the most recent April 2026 update of the charter.

RESOLVED, That our AMA immediately oppose any executive order or federal administrative action that changes or proposes to change the United States vaccine schedules without proper evidence and scientific review by an appropriately convened Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) per the approved charter prior to June 2025.

RESOLVED, That our AMA oppose any alignment of the United States vaccine schedules with other international recommendations that do not strictly account for unique U.S. domestic data and demographics.

RESOLVED that our American Medical Association amend Policy D-440.902 by addition and deletion to read as follows:

1. Our American Medical Association will continue~~initiate~~ sustained public advocacy in support of the ~~current~~previous Advisory Committee on Immunization Practices (ACIP) structure, including the liaison representative program, as outlined in ACIP's 2024 Charter and practiced until Spring 2025.
2. Our AMA ~~will immediately send a letter to the Secretary of Health and Human Services calling for an immediate reversal of the recent changes to the Advisory Committee on Immunization Practices~~ pursue all appropriate channels to reverse the 2025-2026 changes to ACIP's structure, membership, and operations.

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3. Our AMA ~~will immediately send a letter to the Senate Committee on Health, Education, Labor, and Pensions (HELP) and~~ request an investigation into the actions of the U.S. Secretary of Health and Human Services regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.
4. Our AMA will continue to identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary; and be it further

RESOLVED, that our AMA condemns the arbitrary and unilateral 2026 alterations to the ACIP charter, which appear to have been designed to subvert the authority of relevant Federal judges and to allow the appointment of unqualified committee members and liaisons to the Advisory Committee on Immunization Practices (ACIP); and be it further

RESOLVED, that our AMA will collaborate with interested state and specialty societies to support litigation against changes to the ACIP charter, budget, operating principles and staffing which produce ongoing harm to the public's health, and many of which were adopted without adequate and meaningful opportunity for public comment; and be it further

RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the most recent update of the charter.

Your Reference Committee heard supportive testimony on this resolution with strong recognition that the ACIP plays a critical role in public health. Those who testified opposed the recent changes to ACIP and CDC vaccine recommendations and support restoring an evidence-based and transparent process. Changes that limit access to effective vaccines have real consequences for patients and place lives at risk. CSAPH posted an informational comment noting that as of May 2026, the U.S. Department of Health and Human Services rescinded the revised ACIP charter after acknowledging it failed to follow the required public comment process before implementing the changes. It was acknowledged in testimony that given the possibility of additional changes to the charter this year, we should be more specific in referencing the April 2026 changes to the charter to help ensure clarity. Additional resolve clauses were also proposed to address a recent executive order asking for changes to the United States vaccine schedules to align our vaccine recommendations with those of other nations. There was overwhelming support for these additional resolve clauses and acknowledgement that we cannot rely on data from other countries to make vaccine recommendations for the unique U.S. population and context. The AMA Office of General Council had an issue with the use of the word "challenge" in the proffered amendment in the fifth Resolve. "Challenge" would limit us to taking legal action while "oppose" broadens our opportunity to respond, including legal action. Therefore, your Reference Committee recommends adoption as amended.

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(32) RESOLUTION 417 - RESPIRATORY PROTECTION FOR WILDLAND FIREFIGHTERS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 417 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for the adoption of evidence based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to ~~NFPA 1984-compliant, NIOSH-approved Class 2 or Class 3 respirators, and protocols that balance respiratory protection with heat and~~ National Institute of Occupational Safety and Health (NIOSH) Approved respiratory protective devices and other exposure mitigation technologies appropriate for wildland operations; and operational protocols that balance respiratory protection with heat stress, physiological burden, communication, visibility, and exertional demands while maximizing incorporation of the performance objectives and protective elements described in National Fire Protection Association (NFPA) 1984 until fully NFPA 1984-certified products become commercially available (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 417 be adopted as amended.

HOD ACTION: Resolution 417 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association advocate for the adoption of evidence based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to National Institute of Occupational Safety and Health (NIOSH) Approved respiratory protective devices and other exposure mitigation technologies appropriate for wildland operations; and operational protocols that balance respiratory protection with heat stress, physiological burden, communication, visibility, and exertional demands while maximizing incorporation of the performance objectives and protective elements described in National Fire Protection Association (NFPA) 1984 until fully NFPA 1984-certified products become commercially available (Directive to Take Action).

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RESOLVED, That our AMA join the American College of Occupational and Environmental Medicine (ACOEM) in advocating for relevant federal and state fire agencies, forestry departments, and occupational safety organizations to research, develop, and field test lightweight, low-breathing-resistance (<=80 mm H_2O at 150 L/min) respirators and related controls better suited for prolonged wildland use (8 or more hours); and

RESOLVED, That our AMA advocate for the creation of surveillance and longitudinal medical monitoring programs for wildland firefighters to support registries and studies evaluating respiratory protection effectiveness, acute and chronic health risks, and mitigation strategies.

RESOLVED, That our American Medical Association (AMA) advocate for the adoption of evidence based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to NFPA 1984-compliant, NIOSH-approved Class 2 or Class 3 respirators, and protocols that balance respiratory protection with heat and exertion demands; and

RESOLVED, That our AMA join the American College of Occupational and Environmental Medicine (ACOEM) in advocating for relevant federal and state fire agencies, forestry departments, and occupational safety organizations to research, develop, and field test lightweight, low-breathing-resistance (<=80 mm H_2O at 150 L/min) respirators and related controls better suited for prolonged wildland use (8 or more hours); and

RESOLVED, That our AMA advocate for the creation of surveillance and longitudinal medical monitoring programs for wildland firefighters to support registries and studies evaluating respiratory protection effectiveness, acute and chronic health risks, and mitigation strategies.

Your Reference Committee heard supportive testimony for this resolution from multiple societies and individuals. Testimony reinforced the importance of needed personal protection equipment for wildland firefighters who are routinely (and more frequently) exposed to many hazardous pollutants when fighting wildfires, but respirators are difficult to wear due to the physical exertion required for this occupation. During the in-person hearing, a representative from CDC/NIOSH was supportive of the intent of the resolution but offered an amendment noting that the resolution as written was not achievable based on current respirator technology. Additionally, they noted that NIOSH does not use the Class 2/3 system for respirators, making this resolution inaccurate. The authors of the resolution were supportive of proffered amendment as long as the spirit of the original resolution was maintained. It was also noted that increased surveillance and research on this issue was an important need. Your Reference Committee believes the CDC proffered amendment strengthens this resolution and therefore recommends Resolution 417 be adopted as amended.

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(33) RESOLUTION 418 - ENSURING ACCESS TO FULL HIV POST-EXPOSURE PROPHYLAXIS (PEP) COURSES FOR SURVIVORS OF SEXUAL ASSAULT

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve clause of Resolution 418 be amended by addition to read as follows:

RESOLVED, that our AMA amend H-20.900 "HIV, Sexual Assault, and Violence" as follows:

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault, including minors, who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at least at recommended intervals consistent with current clinical guidelines if the initial test is negative or as appropriate per individual, and that strict confidentiality of test results be maintained; and
(2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault at no cost to the survivor.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 418 be adopted as amended.

HOD ACTION: Resolution 418 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault.

H-20.900 "HIV, Sexual Assault, and Violence"

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Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault, including minors, who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested at least at recommended intervals consistent with current clinical guidelines if the initial test is negative or as appropriate per individual, and that strict confidentiality of test results be maintained; and
(2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault at no cost to the survivor.

RESOLVED, that our American Medical Association encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault; and be it further

RESOLVED, that our AMA amend H-20.900 "HIV, Sexual Assault, and Violence" as follows:

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at recommended intervals consistent with current clinical guidelines if the initial test is negative, and that strict confidentiality of test results be maintained; and

(2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault.

Your Reference Committee heard testimony that was mostly supportive of Resolution 418. Multiple delegations, sections, and individuals emphasized the importance of ensuring that survivors of sexual assault have timely and uninterrupted access to the full recommended course of HIV post-exposure prophylaxis (PEP), noting that barriers such as cost, access, and care fragmentation may prevent completion of therapy and place survivors at increased risk. Amendments were proffered to explicitly include minors and to address financial barriers by ensuring access to the full course of therapy without cost to survivors. The authors were in support of these amendments. Therefore, your Reference Committee recommends that Resolution 418 be adopted as amended.

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(34) RESOLUTION 419 - EXAMINING THE IMPACT OF CIRCADIAN DISRUPTION FROM SHIFT WORK DURING PREGNANCY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 419 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association study and report back by A-27 on ~~supports the study of the impact of~~ evidence-informed scheduling and workplace accommodation principles to mitigate circadian disruption from shift work for people trying to conceive and pregnant people, including medical trainees, when feasible and consistent with patient care needs, applicable law, and local staffing realities, ~~during pregnancy, including implications for maternal and fetal health;~~ (Directive to take action) and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 419 be deleted:

~~RESOLVED, that our AMA encourages dissemination of evidence-informed approaches to scheduling and workplace accommodations for pregnant individuals and people trying to conceive, including medical trainees, as appropriate based on the findings of the A-27 report a report on circadian disruption from shift work during pregnancy.~~ (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 419 be deleted:

~~RESOLVED, that our AMA recognizes circadian disruption from night, rotating, and extended shift work as an occupational health issue that may negatively affect reproductive, maternal, and fetal health.~~

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 419 be adopted as amended.

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HOD ACTION: Resolution 419 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association study and report back by A-27 on evidence-informed scheduling and workplace accommodation principles to mitigate circadian disruption from shift work for people trying to conceive and pregnant people, including medical trainees, when feasible and consistent with patient care needs, applicable law, and local staffing realities (Directive to take action).

RESOLVED, that our American Medical Association supports the study of the impact of circadian disruption from shift work during pregnancy, including implications for maternal and fetal health; and be it further

RESOLVED, that our AMA encourages dissemination of evidence-informed approaches to scheduling and workplace accommodations for pregnant individuals as appropriate based on the findings of a report on circadian disruption from shift work during pregnancy.

Your Reference Committee heard mostly supportive testimony for this resolution. Both in-person and online comments recognized that circadian disruption during pregnancy can lead to poor outcomes among those who perform shift work, with particular concern for medical specialties involving extended call or overnight duties. The preliminary report included amendments broadening the resolution's scope to emphasize trainees and people attempting to conceive. There was debate about whether current evidence clearly links shift work to adverse maternal and fetal outcomes, or if more research is needed, which was echoed in in-person testimony. An amendment was offered to request a study by our AMA on evidence-informed scheduling and workplace accommodations to mitigate the health impacts of circadian disruption, with a report back by Annual 2027. This amendment received near-unanimous support, except from one section that expressed concerns about the lack of high-quality data and the possibility of duplicating existing low-quality studies. However, it was clarified that the requested study should focus on disseminating evidence-based accommodations and scheduling, not conducting primary scientific research. This amendment also included an additional resolve clause 3 which directed our AMA to recognize circadian disruption as an occupational health issue. Given the broad support for the amendments, your Reference Committee recommends that Resolution 419 be adopted as amended.

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(35) RESOLUTION 420 - EXPANDING SUPPORT FOR WOMEN EXPERIENCING HOMELESSNESS

RECOMMENDATION A:

Your Reference Committee recommends Resolution 420 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend H-160.903 "Eradicating Homelessness" by addition and deletion as follows:

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.

2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches, in addition to considerations such as having minors in their care, and including women Veterans.

3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.

4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible, including trauma-informed and military-informed approaches for women Veterans who may have experienced military sexual trauma (MST), post-traumatic stress disorder (PTSD), intimate partner violence, or challenges associated with transition from military to civilian life.

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5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.

6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of ~~homeless patients~~ individuals experiencing homelessness, including gender-specific health needs, the unique social determinants of health impacting women Veterans, and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.

8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.

9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability, and women Veterans and military-connected women.

10. Our AMA:
a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.

11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and

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communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

12. Our AMA:
a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;
b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; ~~and~~
c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and
d. encourages incorporation of military service history and Veteran status screening into healthcare and homelessness outreach settings in order to identify women Veterans at risk for homelessness and connect them with appropriate federal, state, local, and community-based resources.

13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement, including educational components addressing Veteran health, military cultural competence, and the healthcare needs of women Veterans experiencing housing instability or homelessness.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 420 be adopted as amended.

HOD ACTION: Resolution 420 be adopted as amended.

ADOPTED LANGUAGE:
Policy H-160.903 "Eradicating Homelessness"

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.

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2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches, in addition to considerations such as having minors in their care, and including women Veterans.

3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.

4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible, including trauma-informed and military-informed approaches for women Veterans who may have experienced military sexual trauma (MST), post-traumatic stress disorder (PTSD), intimate partner violence, or challenges associated with transition from military to civilian life.

5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.

6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of individuals experiencing homelessness, including gender-specific health needs, the unique social determinants of health impacting women Veterans, and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.

8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.

9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability, and women Veterans and military-connected women.

10. Our AMA:

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a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.

11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

12. Our AMA:
a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;
b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals;
~~and~~
c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and
d. encourages incorporation of military service history and Veteran status screening into healthcare and homelessness outreach settings in order to identify women Veterans at risk for homelessness and connect them with appropriate federal, state, local, and community-based resources.

13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement, including educational components addressing Veteran health, military cultural competence, and the healthcare needs of women Veterans experiencing housing instability or homelessness.

RESOLVED, that our American Medical Association amend H-160.903 “Eradicating Homelessness” by addition and deletion as follows:

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches.

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3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of ~~homeless patients~~ individuals experiencing homelessness, including gender-specific health needs and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability.
10. Our AMA:
a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;
b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

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Your Reference Committee heard supportive testimony for this resolution, which seeks to strengthen existing AMA policy on homelessness and the gender-specific needs of individuals experiencing homelessness. Testimony supported the amendments to existing policy, and additional testimony requested further amendments to recognize the importance of veteran health equity and risk of homelessness among female veterans. An additional amendment was proffered to broaden the scope of individuals experiencing homelessness to include children under the care of homeless mothers. The sponsoring section testified in agreement with these amendments; therefore, your Reference Committee recommends that Resolution 420 be adopted as amended.

(36) RESOLUTION 425 - PRIORITIZING, MEASURING, AND PREVENTING WORKPLACE VIOLENCE IN HEALTH CARE

RECOMMENDATION A:

Your Reference Committee recommends that the sixth Resolve clause of Resolution 425 be amended by deletion to read as follows:

RESOLVED, that our AMA rescind existing policies ~~H-515.957 (Preventing Violent Acts Against Health Care Providers),~~ D-515.983 (Preventing Violent Acts Against Health Care Providers)~~,~~ and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 425 be amended by addition of a seventh Resolve clause to read as follows:

RESOLVED, that our American Medical Association seek legislation, and/or craft model state legislation, calling for civil and/or criminal penalties to be established for any healthcare institution or administrator that tries to discourage, or in any way disincentivize, the reporting of workplace violence (New HOD Policy);

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 425 be adopted as amended.

HOD ACTION: Resolution 425 be adopted as amended.

ADOPTED LANGUAGE:

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RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies.

RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy.

RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition.

RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings.

RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce.

RESOLVED, that our AMA rescind existing policies D-515.983 (Preventing Violent Acts Against Health Care Providers) and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)

RESOLVED, that our American Medical Association seek legislation, and/or craft model state legislation, calling for civil and/or criminal penalties to be established for any healthcare institution or administrator that tries to discourage, or in any way disincentivize, the reporting of workplace violence (New HOD Policy).

RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies; and be it further

RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy; and be it further

RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition; and be it further

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RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings; and be it further

RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce; and be it further

RESOLVED, that our AMA rescind existing policies H-515.957 (Preventing Violent Acts Against Health Care Providers), D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace).

Your Reference Committee heard supportive testimony for the spirit of this resolution, and there was unanimous agreement that workplace violence is an increasing risk to health care workers and should be recognized as a national advocacy priority for AMA. Multiple delegations, sections, and individuals shared personal stories about the growing threat of violence towards health care workers and noted that concrete solutions have not materialized to address the issue. The final resolve clause of the resolution recommended rescinding existing AMA policies to streamline efforts to reduce workplace violence and develop a coherent framework. However, your Council on Science and Public Health testified to recommend that policy H-515.957 not be rescinded, as it contains important components that are not captured in the new policy. This recommendation received testimony in support. There was additional testimony from one individual that called for further education of health care workers on the topic of workplace violence. Your Reference Committee acknowledged this request but did not feel that education for health care workers in regard to workplace violence is very effective and therefore this amendment should not be included. Lastly, there was testimony that requested an additional resolve clause to encourage civil and criminal penalties for institutions and administrators that disincentivize or discourage the reporting of workplace violence. This additional resolve also received supportive testimony. Your Reference Committee feels that the proffered amendments appropriately address the concerns raised and therefore recommends that Resolution 425 be adopted as amended.

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(37) RESOLUTION 426 - INTEGRATING NUTRITION INTO HEALTH CARE DELIVERY TO REDUCE CARDIOVASCULAR RISK AND FOOD INSECURITY ("FOOD IS MEDICINE")

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recognizes "f~~F~~ood is ~~M~~medicine" interventions—including medically tailored meals, medically tailored groceries, and produce prescription programs—as promising evidence-~~based~~informed strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity, while supporting continued research and evaluation of these interventions; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for "f~~F~~ood is ~~M~~medicine" initiatives through the yearly Labor–HHS appropriations process; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance "f~~F~~ood is ~~M~~medicine" interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs.

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RECOMMENDATION D:

Your Reference Committee recommends that Resolution 426 be adopted as amended.

HOD ACTION: Resolution 426 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association recognizes "food is medicine" interventions—including medically tailored meals, medically tailored groceries, and produce prescription programs—as promising evidence-informed strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity, while supporting continued research and evaluation of these interventions.

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for "food is medicine" initiatives through the yearly Labor–HHS appropriations process.

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance "food is medicine" interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs.

RESOLVED, that our American Medical Association recognizes Food is Medicine interventions—including medically tailored meals—as evidence-based strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity; and be it further

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for Food is Medicine initiatives through the yearly Labor–HHS appropriations process; and be it further

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance Food is Medicine interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs.

Your Reference Committee heard mostly supportive testimony from multiple sections and individuals for this resolution. However, one individual proffered an amendment to the resolution that would acknowledge that the evidence on food is medicine interventions is evolving and further research is needed. The resolution authors appreciated the thoughtful review of evidence and suggested an alternative amendment to the first resolve that both acknowledges the current evidence that supports the food is medicine approach as well as the need for further research and evaluation. Overall, the testimony noted the importance of nutrition as a foundational pillar of lifestyle medicine and the importance of

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nutrition in preventing and managing chronic disease. Your Reference Committee felt the proffered amendment by the resolution authors appropriately incorporates the concerns raised and that Food is Medicine should be put in quotes and not capitalized (i.e., “food is medicine”) to be consistent with the resolution title and to avoid the impression that the AMA is endorsing any trademarked program or organization. Therefore, your Reference Committee recommends Resolution 426 be adopted as amended.

(38) RESOLUTION 427 - INFANT FEEDING OPTIONS FOR HIV-SEROPOSITIVE INDIVIDUALS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 427 be amended by addition and deletion to read as follows:

RESOLVED, that the American Medical Association amend Policy H-20.916, “Breastfeeding and HIV Seropositive People,” by addition and deletion as follows:

Breastfeeding and HIV Seropositive People, H-20.916
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. ~~be counseled not to breastfeed and not to donate breast milk.~~ HIV testing of all human milk donors should be mandatory, and milk from HIV-positive donors, even if the viral load is suppressed, should not be donated ~~HIV-infected donors should not be used for human consumption~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 427 be adopted as amended.

HOD ACTION: Resolution 427 be adopted as amended.

ADOPTED LANGUAGE:
Policy H-20.916, “Breastfeeding and HIV Seropositive People”
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about

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infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. HIV testing of all human milk donors should be mandatory, and milk from HIV-positive donors, even if the viral load is suppressed, should not be donated.

RESOLVED, that the American Medical Association amend Policy H-20.916, "Breastfeeding and HIV Seropositive People," by addition and deletion as follows:

Breastfeeding and HIV Seropositive People, H-20.916
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. ~~be counseled not to breastfeed and not to donate breast milk.~~ HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption.

Your Reference Committee heard testimony that was strongly supportive of Resolution 427. Multiple delegations, sections, and individuals emphasized the importance of updating existing AMA policy to reflect current evidence regarding breastfeeding among people living with HIV, noting that transmission risk is very low in individuals with sustained viral suppression on antiretroviral therapy. A delegation proffered an amendment to clarify language regarding breast milk donation, specifically to maintain existing safety standards prohibiting donation from individuals who are HIV positive, regardless of viral load. Given that this amendment is consistent with the intent of the resolution, your Reference Committee recommends that Resolution 427 be adopted as amended.

(39) RESOLUTION 428 - PROTECTING ENVIRONMENTAL HEALTH BEFORE, DURING, AND AFTER WAR

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 428 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities ~~that the U.S. is involved in~~; and be it further

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RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 428 be amended by deletion to read as follows:

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to ~~U.S. and U.S.-supported~~ military activities, including armed conflict and weapons production, that lead to adverse health outcomes; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 428 be adopted as amended.

HOD ACTION: Resolution 428 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities.

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to military activities, including armed conflict and weapons production, that lead to adverse health outcomes.

RESOLVED, that our AMA supports the development, availability, and use of continued medical education for clinicians to take exposure histories, counsel patients, and report sentinel events in displaced and conflict-affected populations impacted by environmental health harms.

RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities that the U.S. is involved in; and be it further

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to U.S. and U.S.-supported military activities, including armed conflict and weapons production, that lead to adverse health outcomes; and be it further

RESOLVED, that our AMA supports the development, availability, and use of continued medical education for clinicians to take exposure histories, counsel patients, and report sentinel events in displaced and conflict-affected populations impacted by environmental health harms.

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Your Reference Committee heard limited but generally supportive testimony for this resolution from multiple sections and one individual. One delegation was generally supportive of the spirit of this resolution but requested the second resolve be referred as they believed the economic and financial implications of cleaning up the environmental impacts of military activities were too immense for inclusion in this resolution. Another individual proffered a friendly amendment to remove the references to U.S. and U.S. involved military activities to broaden the resolution's scope. The Resolution authors responded by noting that they were open to the suggested friendly amendments as long as the policy remained actionable and that the resolution as written does not prescribe a funding mechanism, assign implementation responsibility, or mandate specific remediation actions. Therefore, they were opposed to referral of the second resolve. Your Reference Committee agrees with the resolution authors and recommends Resolution 428 be adopted as amended.

(40) RESOLUTION 431 - SUPPORTING TRANSPORTATION INFRASTRUCTURE REFORM FOR PUBLIC HEALTH

RECOMMENDATION A:

Your Reference Committee recommends the first Resolve clause of Resolution 431 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure that prioritizes the health, safety, and accessibility of all road users using context-sensitive designs; 2.) ~~ensure safe and accessible travel for pedestrians, bicyclists, public transit users, and motorists of all ages and abilities~~ prioritize developing a transportation system with zero deaths and zero serious injuries for all road users regardless of age or ability; and 3.) ensure everyone has the right to access roads that are designed with the safety of all users in mind, placinge a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 431 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support reform of federal transportation non-motorized travel performance monitoring and funding formulas, to explicitly prioritize vulnerable road user~~pedestrian safety~~ metrics, ~~transit~~

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accessibility to destinations and services such as transit, jobs, and healthcare, and other health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 431 be adopted as amended.

HOD ACTION: Resolution 431 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure that prioritizes the health, safety, and accessibility of all road users using context-sensitive designs; 2.) prioritize developing a transportation system with zero deaths and zero serious injuries for all road users regardless of age or ability; and 3.) ensure everyone has the right to access roads that are designed with the safety of all users in mind, placing a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color;

RESOLVED, that our AMA support reform of federal transportation non-motorized travel performance monitoring and funding formulas, to explicitly prioritize vulnerable road user metrics, accessibility to destinations and services such as transit, jobs, and healthcare, and other health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads.

RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure; 2.) ensure safe and accessible travel for pedestrians, bicyclists, public transit users, and motorists of all ages and abilities; and 3.) place a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color; and be it further

RESOLVED, that our AMA support reform of federal transportation funding formulas, to explicitly prioritize pedestrian safety metrics, transit accessibility, and health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads.

Your Reference Committee heard mostly unanimously supportive testimony for this resolution from multiple sections and delegations. The testimony highlighted the importance of multimodal infrastructure to support accessibility and equity for all, and that transportation infrastructure reform can help to reduce health disparities by improving access to care and accessibility for individuals who face mobility impairments. Testimony noted the timeliness of the resolution, as pedestrian fatalities have currently reached a 40-year high. During the in-person hearing, a representative from the CDC testified in support of the resolution with a proffered amendment. While there was no additional testimony in

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support of this amendment, your Reference Committee generally felt that the proposed amendments strengthened the resolution, making it more aspirational and inclusive of all road users. The only component of the proposed amendment your Reference Committee did not agree with was the deletion of language around undeserved communities and we felt it was important to include that original language to address concerns around health equity and disparities. Therefore, your Reference Committee recommends that Resolution 431 be adopted as amended.

(41) RESOLUTION 432 - ADDRESSING PUBLIC HEALTH RISKS OF ONLINE SPORTS BETTING

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 432 be amended by addition to read as follows:

RESOLVED, that our American Medical Association supports efforts to establish federal and state consumer protections for online gambling, including sports betting, prediction markets, and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors (New HOD Policy);

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 432 be amended by addition to read as follows:

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting, prediction markets, and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations (New HOD Policy).

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 432 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 432 be changed to read as follows:

ADDRESSING PUBLIC HEALTH RISKS OF ONLINE GAMBLING

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HOD ACTION: Resolution 432 be adopted as amended.

ADOPTED LANGUAGE:
Addressing Public Health Risks of Online Gambling

RESOLVED, that our American Medical Association supports efforts to establish federal and state consumer protections for online gambling, including sports betting, prediction markets, and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors (New HOD Policy);

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting, prediction markets, and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations (New HOD Policy).

RESOLVED, that our American Medical Association support efforts to establish federal and state consumer protections for online gambling, including sports betting and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors; and be it further

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations.

Your Reference Committee heard supportive testimony for this resolution, with multiple sections, delegations, and coalitions testifying that the highly addictive and fast-growing area of online sports betting represents a significant public health concern. There was a request to add an amendment to include the effects of gambling within the prediction markets, which received supportive testimony in agreement. To address these concerns, your Reference Committee suggested amendments to Resolves one and two to include prediction markets in the request for further study and consumer protection advocacy efforts. With the inclusion of prediction markets, your Reference Committee felt the title of this resolution should also be broadened to encompass online gambling and betting more generally. Therefore, your Reference Committee recommends that Resolution 432 be adopted as amended and the title be changed.

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(42) RESOLUTION 436 - PROTECTING CHILDREN FROM POTENTIAL HARMS OF CAFFEINATED PRODUCTS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 436 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend existing policy H-150.988 by addition to read:

The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label; also, that children under the age of 12 years old should avoid caffeinated products entirely and those ~~under~~ between the age of 12 and 18 should limit intake to <100mg per day as supported by evidence-based research and guidelines.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 436 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA amend existing policy D-150.976 by addition to read:

1. **Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)), with special attention to scientific evidence of harm to children ~~below ages 12 and 18.~~ less than 12 years old and adolescents between 12 and 18 years old.**
2. **Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol with specific warning of harm to children below the age of 18.**
3. **Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18, including opposing commercial**

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advertising, sponsorships, and promotional practices that target or appeal to children and adolescents. **(Amend HOD Policy)**

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 436 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that policy H-150.988, Caffeine Labeling be reaffirmed.

HOD ACTION: Resolution 436 be adopted as amended.

ADOPTED LANGUAGE:
H-150.988, "Caffeine Labeling"
The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label; also, that children under the age of 12 years old should avoid caffeinated products entirely and those between the age of 12 and 18 should limit intake to <100mg per day as supported by evidence-based research and guidelines.

D-150.976, "Hazards of Energy Beverages - Their Abuse and Regulation"
1)Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)), with special attention to scientific evidence of harm to children less than 12 years old and adolescents between 12 and 18 years old.
2) Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol with specific warning of harm to children below the age of 18.
3) Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18, including opposing commercial advertising, sponsorships, and promotional practices that target or appeal to children and adolescents. (Amend HOD Policy)

RESOLVED, that our American Medical Association amend existing policy H-150.988 by addition to read:
The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label; also, that children under the age

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of 12 years old should avoid caffeinated products entirely and those under the age of 18 should limit intake to <100mg per day as supported by evidence-based research and guidelines.

RESOLVED, that our AMA amend existing policy D-150.976 by addition to read:
1. Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)) with special attention to scientific evidence of harm to children below ages 12 and 18.

2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol with specific warning of harm to children below the age of 18.

3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18, including opposing commercial advertising, sponsorships, and promotional practices that target or appeal to children and adolescents. (Amend HOD Policy)

Your Reference Committee heard mostly supportive testimony on this resolution, which highlighted the harms of highly caffeinated products on youths and adolescents. Testimony noted that caffeinated products can lead to detrimental health problems in young people and are increasingly accessible. An amendment was proffered to clarify grammatical structure and to emphasize that the risk of caffeine is compounded in children under the age of 12. This amendment received supportive testimony, and your Reference Committee made amendments to have consistent language in the policy. Additionally, your Reference Committee heard testimony on the importance of labelling caffeine content in products and therefore felt it was also important to reaffirm existing AMA policy on this issue. Therefore, your Reference Committee recommends that Resolution 436 be adopted as amended.

(43) RESOLUTION 439 - AGE VERIFICATION AND ENDS PRODUCTS

RECOMMENDATION A:

Your Reference Committee recommends that the third Resolve clause of Resolution 439 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate to FDA and others, that the sponsor of any electronic nicotine delivery system (ENDS) product considered for FDA authorization ~~authorized~~ ~~product~~ be required to share the data used to prove the effectiveness and durability of age-verification used; and be it further

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RECOMMENDATION B:

Your Reference Committee recommends that the fourth Resolve clause of Resolution 439 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that the FDA Committee on Tobacco Products ~~CTP~~ require and implement effective post market surveillance data collection to measure the effectiveness and durability of any ENDS age-verification systems; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the sixth Resolve clause of Resolution 439 be amended by addition to read as follows:

RESOLVED, that our AMA advocate that the FDA establish and maintain a high proof of effectiveness and durability threshold for age-verification systems for ENDS products ~~that rely on age-verification systems~~ to prevent youth access ~~initiation~~.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 439 be adopted as amended.

HOD ACTION: Resolution 439 be adopted as amended.

ADOPTED LANGUAGE:
RESOLVED, that our American Medical Association opposes FDA's decision to authorize ENDS products with fruit characterizing flavors.

RESOLVED, that our AMA continues to oppose the authorization of any ENDS products with characterizing flavors, including but not limited to fruit, candy, dessert, mint, and menthol flavors, that may enhance the appeal of such products to youth.

RESOLVED, that our AMA advocate to FDA and others, that the sponsor of any electronic nicotine delivery system (ENDS) product considered for FDA authorization be required to share the data used to prove the effectiveness and durability of age-verification used.

RESOLVED, that our AMA advocate that the FDA Committee on Tobacco Products require and implement effective post market surveillance data collection to measure the effectiveness and durability of any ENDS age-verification systems.

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RESOLVED, that our AMA urge FDA to take immediate action to remove authorized ENDS products from the market should age-verification technology prove to be insufficient to prevent youth initiation.

RESOLVED, that our AMA advocate that the FDA establish and maintain a high proof of effectiveness and durability threshold for age-verification systems for ENDS products to prevent youth access.

RESOLVED, that our American Medical Association opposes FDA's decision to authorize ENDS products with fruit characterizing flavors; and be it further

RESOLVED, that our AMA continues to oppose the authorization of any ENDS products with characterizing flavors, including but not limited to fruit, candy, dessert, mint, and menthol flavors, that may enhance the appeal of such products to youth; and be it further

RESOLVED, that our AMA advocate FDA and any future authorized product share the data used to prove the effectiveness and durability of age-verification used; and be it further

RESOLVED, that our AMA advocate FDA CTP require and implement effective post market surveillance data collection to measure the effectiveness and durability of any ENDS age-verification systems; and be it further

RESOLVED, that our AMA urge FDA to take immediate action to remove authorized ENDS products from the market should age-verification technology prove to be insufficient to prevent youth initiation; and be it further

RESOLVED, that our AMA advocate FDA establish and maintain a high proof of effectiveness and durability threshold for ENDS products that rely on age-verification systems to prevent youth initiation.

Your Reference Committee heard strong support for this resolution with acknowledgement that it has long been a priority of the AMA to protect young people from nicotine addiction and the resulting health risks. Disappointment was expressed regarding the FDA's recent policy shift to authorize fruit-flavored ENDS products to be sold in the U.S. Amendments were suggested to clarify the language and to spell out acronyms. Your Reference Committee agrees with these amendments. In the last Resolve your Reference Committee amended the language to make it clear that the proof of effectiveness and durability threshold was for the age-verification systems and not the ENDS products themselves. Therefore, your Reference Committee recommends that this resolution be adopted as amended.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(44) RESOLUTION 438 - PRESERVING AND STRENGTHENING MATERNAL MORTALITY REVIEW COMMITTEES

RECOMMENDATION:

Your Reference Committee recommends Alternate Resolution 438 be adopted in lieu of Resolution 438.

PRESERVING AND STRENGTHENING MATERNAL MORTALITY REVIEW COMMITTEES (MMRCs)

RESOLVED, that our American Medical Association strongly opposes actions that undermine the independence, transparency, or scientific integrity of maternal mortality review and condemns undue interference with state MMRCs; and be it further

RESOLVED, that our AMA urge Congress to:
a) Require that all states use centralized maternal child health surveillance and data systems, such as the Maternal Mortality Review Information Application, to ensure ability to aggregate US maternal data;
b) Ensure timely public reporting of findings and recommendations while maintaining individual case confidentiality; and
c) Create whistleblower protections for MMRC members who report undue influence or data suppression (Directive to Take Action); and be it further

RESOLVED, that our AMA calls upon state medical societies and physician advocates to:
a) Monitor state MMRC activities for signs of interference or funding threats; and
b) Support MMRC recommendations that lead to quality improvement, reduction in preventable deaths, and address non-medical drivers of health; and be it further

RESOLVED, that our AMA reaffirm H-60.909, State Maternal Mortality Review Committees.

HOD ACTION: Alternate Resolution 438 be adopted in lieu of Resolution 438.

ADOPTED LANGUAGE:
PRESERVING AND STRENGTHENING MATERNAL MORTALITY REVIEW COMMITTEES (MMRCs)

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RESOLVED, that our American Medical Association strongly opposes actions that undermine the independence, transparency, or scientific integrity of maternal mortality review and condemns undue interference with state MMRCs.

RESOLVED, that our AMA urge Congress to:

a) Require that all states use centralized maternal child health surveillance and data systems, such as the Maternal Mortality Review Information Application, to ensure ability to aggregate US maternal data;

b) Ensure timely public reporting of findings and recommendations while maintaining individual case confidentiality; and

c) Create whistleblower protections for MMRC members who report undue influence or data suppression (Directive to Take Action).

RESOLVED, that our AMA calls upon state medical societies and physician advocates to:

a) Monitor state MMRC activities for signs of interference or funding threats; and

b) Support MMRC recommendations that lead to quality improvement, reduction in preventable deaths, and address non-medical drivers of health.

RESOLVED, that our AMA reaffirm H-60.909, State Maternal Mortality Review Committees.

RESOLVED, that our AMA supports federal legislation establishing minimum standards and protections for state MMRCs, including:

a) Mandatory comprehensive review of all pregnancy-associated deaths (during pregnancy through one year postpartum) regardless of cause

b) Required access to all relevant medical records, death certificates, autopsy reports, and related documentation

c) Confidentiality protections and immunity from liability for committee members and information providers

d) Protection of committee deliberations and findings from discovery in civil or criminal proceedings

e) Requirements for representative, multidisciplinary committee membership including community representatives with personal experience

f) Prohibition on political interference in committee composition, case selection, or recommendation development

g) Timely public reporting of aggregated findings and recommendations while maintaining individual case confidentiality

h) Accountability mechanisms for states that fail to conduct comprehensive, timely maternal death reviews; and be it further

RESOLVED, that our AMA urge Congress to:

a) Require all states use centralized maternal child health surveillance and data systems, such as MMRIA, to ensure consolidated US maternal data

b) Require states to review all pregnancy-associated deaths without exception for specific time periods or circumstances

c) Mandate public disclosure of committee membership composition

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d) Establish accountability for states that fail to implement MMRC recommendations without documented justification
e) Create whistleblower protections for MMRC members who report undue influence or data suppression (Directive to Take Action); and be it further

RESOLVED, that our AMA calls upon state medical societies and physician advocates to:
a) Monitor state MMRC activities for signs of interference or funding threats
b) Advocate for state legislation protecting MMRC independence and adequate funding
c) Support MMRC recommendations that lead to quality improvement, reduction in preventable deaths, and address non-medical drivers of health; and be it further

RESOLVED, that our AMA condemn undue interference with state MMRCs.

Your Reference Committee heard supportive testimony of this resolution noting the importance of preserving the integrity and effectiveness of Maternal Mortality Review Committees (MMRCs), which are critical to identifying preventable maternal deaths and informing evidence-based interventions to improve outcomes. A delegation proffered extensive amendments that maintained the core intent of protecting MMRC independence, data integrity, and transparency, while avoiding overly prescriptive federal mandates that may have unintended consequences. The author of this resolution, multiple sections, and delegations were in support of these amendments. Therefore, your Reference Committee recommends that Alternate Resolution 438 be adopted in lieu of Resolution 438.

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RECOMMENDED FOR REFERRAL

(45) RESOLUTION 406 - REDUCE ENVIRONMENTAL IMPACT OF MEDICAL JOURNALS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 406 be referred.

HOD ACTION: Resolution 406 be referred.

RESOLVED, that our American Medical Association's medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions; and be it further

RESOLVED, that our AMA encourage specialty societies to require physicians to opt in to receive print versions of journals, with the default option being to receive electronic-only versions.

Your Reference Committee heard mixed testimony for this resolution in both online and in-person hearings. While several delegations offered support of the resolution, the AMA Board of Trustees and a few other delegations either recommended it not be adopted or it be referred. Those that supported the resolution noted the environmental impacts of paper journals and that individuals could still choose to receive paper copies if they wanted; this resolution would simply make electronic distribution the default. On the other hand, it was noted that a number of JAMA network journals are already electronically distributed by default, that they have already reduced the number of print copy distribution by 67 percent in the past five years, and that a strategy is already underway to balance the tradeoffs of environmental impact, revenue, engagement, and journal impact. Another delegation that opposed this resolution as written felt it was overly prescriptive and that physicians continue to rely on print publications for multiple reasons. One section proffered an amendment that supported the electronic version as a default while recognizing that a one-size-fits-all approach for journals was not appropriate. This amendment would have added language that organizations should take into account the operational and financial needs of individual journals. The proposed amendment was supported by two other delegations, but the majority of those testifying during the in-person hearing supported referral. The resolution authors testified that they would be amenable to referral as well, but would like the plastic packaging used for paper journals to be considered as part of the forthcoming study. Due to the mixed testimony on this item, your Reference Committee recommends referral.

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(46) RESOLUTION 412 - GUIDING PRINCIPLES OF PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE; SUPPORT FOR THE WORLD HEALTH ORGANIZATION PANDEMIC AGREEMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 412 be referred.

HOD ACTION: Resolution 412 be referred.

RESOLVED, that our American Medical Association support and adopt the following Articles of the World Health Organization Pandemic Agreement as our framework for Pandemic Prevention, Preparedness and Response:

Article 4, Pandemic prevention and surveillance;
- Article 5, One Health approach for Pandemic Prevention, Preparedness and Response;
- Article 6, Preparedness, readiness and health system resilience;
- Article 7, Health and care workforce;
- Article 8, Regulatory systems strengthening;
- Article 9, Research and development;
- Article 10, Sustainable and geographically diversified local production;
- Article 11, Transfer of technology and cooperation on related know-how for the production of - pandemic-related health products;
- Article 12, Pathogen Access and Benefit-Sharing Systems;
- Article 13, Supply chain and logistics;
- Article 14, Procurement and distribution;
- Article 15, Whole-of-government and whole-of-society approaches;
- Article 16, Communication and public awareness;
- Article 17, International cooperation and support for implementation;
- Article 18, Sustainable financing; and be it further.

Your Reference Committee heard mixed testimony for this resolution, with several delegations offering support while the Council and Science and Public Health as well as a few other delegations recommended it either not be adopted or be referred. Supportive testimony highlighted the need for more international collaboration on pandemic preparedness, particularly considering the COVID-19 pandemic and the recent Hantavirus and Ebola outbreaks. Those testifying in favor of referral noted that the AMA was not involved in the development of this agreement and raised concerns about the length and complexity of the referenced articles, which would automatically become AMA policy. It was also noted that the AMA was not involved in the development of this agreement and if the language is changed in the future, AMA policy would automatically be updated with no oversight by AMA's House of Delegates. The Council on Science and Public Health supported not adopting the resolution, citing lack of clarity in its intent and concerns about the exclusion of certain Articles. Given that the majority of the testimony supported referral of this item, your Reference Committee recommends that Resolution 412 be referred.

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(47) BOARD OF TRUSTEES 09 - AMERICAN MEDICAL ASSOCIATION OPTIMAL HEALTH OUTCOMES ANNUAL REPORT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees 09 be referred with report back at I-26.

HOD ACTION: BOT Report 09 be referred with report back at I-26.

This informational report outlines the activities conducted by our AMA during calendar year 2025, divided into the four COHO pillars, demonstrating relevance, impact, and thought leadership: (1) Community Health Impact, (2) Health Systems Engagement, (3) Policy Development and (4) Data and Research.

Testimony noted that the House of Delegates overwhelmingly supported the creation of a Center for Health Equity and the AMA has folded the Center into the Improving Health Outcomes unit allowing the focus to be taken off of addressing health disparities. It was requested that this informational report be referred and that the following questions regarding the impacts of this decision be addressed in a report back to the House of Delegates at I-26:

(1) What AMA strategic priority does combining CHE/IHO to became COHO address?
(2) Was the CHE budget reduced with this COHO reduction?
(3) Was the 50% CHE staff reduction too severe to achieve our reducing health disparities goals?
(4) What are the goals of COHO and now is AMA able to say what those goals are and are we able to measure their level of achievement in the past year?
(5) Please let us know if we ultimately achieve the COHO stated goals by this reorganization?

The Board of Trustees noted that health equity is strengthened when it is integrated into all organizational work and the AMA's decision to merge the Center for Health Equity with the Improving Health Outcomes unit creates greater alignment between identifying health disparities and implementing solutions within communities and health systems. The AMA's commitment to health equity remains reflected in AMA policy and its continued work in this space. Although testimony was limited, everyone who testified besides the author supported referral, and your Reference Committee agrees with this position.

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RECOMMENDED FOR REFERRAL FOR DECISION

(48) RESOLUTION 410 - LIGHT POLLUTION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 410 be referred for decision.

HOD ACTION: Resolution 410 be referred for decision.

RESOLVED, that our American Medical Association update its outdoor lighting recommendations to be:

1. Most outdoor lighting including street lighting should be 2700K or lower
2. Exceptions for inner city high traffic regions could be made for 3000K when deemed necessary for public safety
3. For rural and residential areas, or locations with interest in environmentally friendly policy, strong considerations be given to use 2200K to 2400K outdoor lighting
4. AMA policy on shielding to prevent disability glare should remain unchanged and should have fully shielded light fixtures to limit emission to 10 degrees below the horizontal to limit glare
5. Consideration should be given for streetlight dimming technology on most streetlights for further energy savings at low traffic times and further glare reduction.

Your Reference Committee heard mixed testimony for this resolution, which recommends that AMA update its outdoor lighting recommendations to prevent excessive light pollution and safeguard environmental health. Several sections and delegations testified in support of the resolution, noting that light pollution can cause significant health harms and that current AMA policy should reflect current evidence. An amendment was proffered to recommend that inner city traffic regions be updated to “urban” regions to avoid potentially stigmatizing language, but this amendment received limited supportive testimony. However, your Council on Science and Public Health (CSAPH) testified to recommend that this resolution not be adopted during both the online and in-person hearings, noting that as written, this resolution does not actually amend existing policy and would inadvertently create policy that contradicts itself. The resolution author offered an amendment verbally that would amend existing AMA policy, but these amendments were not received electronically by your Reference Committee and therefore could not be considered. Another section testified that they supported adoption as amended by the resolution author and did not feel further study was necessary. Your Reference Committee agrees that further study on this topic is unnecessary but recognizes that parliamentary rules state that existing AMA policy cannot be amended if it was not included in the original resolution text. Therefore, your Reference Committee recommends that Resolution 410 be referred for decision to ensure a timely outcome on this topic.

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(49) RESOLUTION 434 - VACCINATIONS IN PHYSICIAN OFFICES

RECOMMENDATION:

Your Reference Committee recommends that policy H-440.860 be reaffirmed in lieu of Resolution 434.

HOD ACTION: Policy H-440.860 be reaffirmed in lieu of Resolution 434.

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).

Your Reference Committee heard mostly supportive testimony for the intent of this resolution as it is widely recognized that coverage for recommended vaccines under Medicare Part B would improve patient access to vaccines. However, several clarifying amendments were proposed. There was also an ask to refer this resolution for study as the fiscal implications could undermine efforts to fix budget neutrality and tie payments to the Medicare Economic Index. Your Reference Committee recognizes that existing AMA Policy H-440.860 already supports advocating for easing federally imposed immunization burdens by "providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B." Where relevant, this existing AMA policy references ACIP-recommended vaccines as of May 1st, 2025, and national medical specialty society recommended vaccines, which was raised in testimony in regard to the original resolution. As a result, we do not believe that amending this resolution or referring it for study is necessary. Rather, your Reference Committee recommends that existing policy be reaffirmed in lieu of Resolution 434.

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This concludes the report of Reference Committee . I would like to thank Laurel Barr, MD, Justin Hurie, MD, Janice Heaton-Sheufelt, MD, Karl Steinberg, MD, Chris Bush, MD, Ella Wright, and all those who testified before the Committee, as well as our AMA staff Lindsey Realmuto, Mary Soliman, Katlyn Dillane, and Andrea Garcia.

Laurel Barr, MD
Ohio

Karl Steinberg, MD, Post-Acute & Long-Term Care Medical Association

Justin Hurie, MD
North Carolina

Chris Bush, MD (Alternate)
Michigan

Janice Heaton-Sheufelt, MD
American Academy of Family Physicians

Ella Wright
Regional Medical Student

Cheryl Hurd, MD
American Psychiatric Association
Chair

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DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee E

Raymond Lorenzoni, MD, Chair

RECOMMENDED FOR ADOPTION

1. CSAPH 08 - Increased Transparency Among Psychotropic Drug Administration in Prisons
2. CSAPH 09 - In Support of a National Drug Checking Registry

RECOMMENDED FOR ADOPTION AS AMENDED

3. CSAPH 07 - Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
4. Resolution 501 - Preregistration in Medical Research
5. Resolution 502 - Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
6. Resolution 505 - Avoiding Misuse of Artificial Intelligence (AI) in Clinical Practice
7. Resolution 507 - Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
8. Resolution 512 - Medical Cannabis Use in Older Adults
9. Resolution 513 - Access, Affordability, and Safety of GLP-1 Receptor Agonists
10. Resolution 515 - Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure
11. Resolution 516 - FDA Regulation of Unapproved Synthetic Peptides

RECOMMENDED FOR ADOPTION IN LIEU OF

12. Resolution 506 - Access To Gender Affirming Healthcare Including Clinical Trials and Resolution 509 - Preserving Gender-Affirming Surgical Care Access
13. Resolution 511 - Preserving Specialty Access to Anti-Cancer Agents
14. Resolution 514 - Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy

RECOMMENDED FOR REFERRAL

15. Resolution 508 - Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
16. Resolution 510 - Exosome and Peptide Use in Healthcare

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RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

17. Resolution 503 - Expansion of Psychedelic Assisted Therapy (PAT)
18. Resolution 504 - Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence

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RECOMMENDED FOR ADOPTION

(1) CSAPH 08 - INCREASED TRANSPARENCY AMONG PSYCHOTROPIC DRUG ADMINISTRATION IN PRISONS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 08 adopted and remainder of Report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1) That policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration," be amended by addition and deletion to read as follows:
A. Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.

Our AMA supports increased transparency from jails and prisons surrounding mental health care, including utilization protocols pertaining to the administration of psychotropic medications, and corresponding patient outcomes, potential harms, and system challenges. including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

B. Our AMA acknowledges the importance of continuity of care for mental health disorders in carceral settings and encourages incorporation of programs and procedures to promote evidence-based continuity of care, including bridge programs, medication verification protocols, access to qualified physicians, and post-release linkage to community clinics for continued care. (Modify Current HOD Policy)

2) That our AMA reaffirm the following HOD policies:
H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" H-430.986, "Health Care While Incarcerated;" D-430.997, "Support for Health Care Services to Incarcerated Persons;" and H-110.958, "Minimum Requirements for Medication Formularies." (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony for this report. Comments noted that the report touched on ensuring patient safety, preserving patient autonomy, continuity of care, and improving transparency and accountability within correctional health systems.

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Therefore, Your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 8 be adopted.

(2) CSAPH 09 - IN SUPPORT OF A NATIONAL DRUG CHECKING REGISTRY

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 09 adopted and remainder of Report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA: (1) supports drug checking that provides real-world insight into the rapidly shifting drug supply, which helps reduce harm among people who use drugs, better inform clinicians, and enhance public health surveillance efforts; (2) advocates for funding and legal authorization to support drug checking services at the local, county, state, and national level; and (3) will continue to monitor ongoing drug checking efforts. (New HOD Policy)

2. That our AMA reaffirm the following HOD policies: H-95.900, "Supporting Harm Reduction,"; H-95.901, "Drug Policy Reform," and D-95.987, "Prevention of Drug-Related Overdose," (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on this report. Testimony noted that the report recommendations are aligned to many delegation and section priorities and provide physicians with insight into how and what substances are being consumed for improving patient counseling and care. Therefore, Your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 9 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(3) CSAPH 07 - FRAMEWORK TO CONVEY EVIDENCE-BASED MEDICINE IN AI TOOLS USED IN CLINICAL DECISION MAKING

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation in the Council on Science and Public Health Report 7 be amended by addition and deletion to read as follows:

1. a. Recognize and promote the importance of transparency and explainability ~~of~~ so physicians have sufficient information to make sound clinical decisions when using AI ~~tools used in~~ clinical decision support tools, which depending on the tool, may include information such as ~~to ensure the quality of medical evidence and~~ the grading of medical evidence including the data sources. ~~are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions.~~

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in CSAPH 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CSAPH Report 07 adopted as amended and remainder of Report filed.

ADOPTED LANGUAGE: The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA will:

a. Recognize and promote the importance of transparency and explainability so physicians have sufficient information to make sound clinical decisions when using AI clinical decision support tools, which depending on the tool, may include information such as the grading of medical evidence including the data sources.

b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.

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c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making.

d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care.

2. Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," be rescinded as having been accomplished by this report.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1.That our AMA will:

a. Recognize and promote the importance of transparency and explainability of AI tools used in clinical decision support to ensure the quality of medical evidence and the grading of medical evidence including the sources are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions.

b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.

c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making.
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d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care. (Directive to Take Action)

2. Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Your Reference Committee heard testimony in strong support of the report and recommendations from multiple sections and delegations. There was concern regarding explainability and its actual function or capability for AI tools, particularly noting that explainability is not always feasible. An amendment was proffered to broaden components of the first recommendation to denote that the physician is the ultimate arbiter of the clinical decision and not the AI tool. Report authors highlighted the work of the AMA on explainability and transparency in AI and its importance as physicians continually strive to implement evidence-based medicine into their clinical decision-making. Given the strong support for the recommendations and collaborative amendment, your Reference Committee recommends the recommendations in Council on Science and Public Health Report 7 be adopted as amended.

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(4) RESOLUTION 501 - PREREGISTRATION IN MEDICAL RESEARCH

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 501 be amended by addition and deletion to read as follows:

Our AMA will:

(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;

(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;

(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;

(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;

(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;

(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and

~~(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.~~

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(7) recognize the importance of preregistration ~~as a cornerstone of~~ in advancing rigorous and reproducible biomedical research~~.~~;and

~~(8) collaborate with relevant stakeholders to advocate for the integration of preregistration into medical research protocols, emphasizing its use for clinical trials, observational studies, and other research contexts;~~

~~(9) collaborate with relevant stakeholders to support efforts to provide training and resources for medical researchers to implement preregistration effectively, including access to standardized registries and education on preregistration practice; and~~

~~(10) collaborate with relevant stakeholders in the medical and scientific community to promote policies and incentives that align preregistration with the goals of career advancement, funding acquisition, and publication, fostering a culture of transparency and accountability in medical research.~~

(8) study the use of preregistration in medical research, including standardized registries, education on preregistration practice, and alignment with transparency and accountability.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 501 be adopted as amended.

HOD ACTION: Resolution 501 be adopted as amended.

ADOPTED LANGUAGE: RESOLVED, that our American Medical Association amend policy H-460.941 by addition and deletion to read as follows:

Our AMA will:

(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;

(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;

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(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;

(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;

(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;

(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care;

(7) recognize the importance of preregistration in advancing rigorous and reproducible biomedical research; and

(8) study the use of preregistration in medical research, including standardized registries, education on preregistration practice, and alignment with transparency and accountability.

RESOLVED, that our American Medical Association amend policy H-460.941 by addition and deletion to read as follows:

Our AMA will:

(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;

(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;

(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;

(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;

(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;

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(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and

~~(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.~~

(7) recognize the importance of preregistration as a cornerstone of rigorous and reproducible biomedical research:

(8) collaborate with relevant stakeholders to advocate for the integration of preregistration into medical research protocols, emphasizing its use for clinical trials, observational studies, and other research contexts;

(9) collaborate with relevant stakeholders to support efforts to provide training and resources for medical researchers to implement preregistration effectively, including access to standardized registries and education on preregistration practice; and

(10) collaborate with relevant stakeholders in the medical and scientific community to promote policies and incentives that align preregistration with the goals of career advancement, funding acquisition, and publication, fostering a culture of transparency and accountability in medical research.

Your Reference Committee heard testimony that was supportive of this resolution in addressing the public and scientific community's call for transparency in clinical research. However, concern was expressed that registries may limit the ability to conduct research that is not pre-registered. There were also calls for reconsideration of the resolution's language, including the term "pre-registration," and a call for referral for study. Given this testimony, the amendments propose a study on the use of pre-registration in clinical research, including topics contained in the original resolution language. The study would also provide an opportunity to define pre-registration. As such, your Reference Committee recommends that Resolution 501 be adopted as amended.

(5) RESOLUTION 502 - SUPPORT FOR RAPID METHADONE INPATIENT STABILIZATION AND LINKAGE TO CARE

RECOMMENDATION A:

Your Reference Committee recommends Resolution 502 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will ~~endorse and~~ advocate for removal of barriers to ~~the implementation of a rapid methadone inpatient stabilization pathway for~~ the development and implementation of pregnancy-specific treatment pathways ~~treatment of Opioid Use Disorder in~~

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~~pregnant~~ for pregnant patients with Opioid Use Disorder, including:

a. Encouraging treatment tailored for pregnancy and the individual patient (i.e. choice of medication, dosage, and frequency of dosing) informed by clinical evaluation, history, available resources, and patient and physician preference;
b. Advocating for medication take home flexibilities for pregnant patients;
c. Ensuring that institutions have care pathways in place to dispense adequate medication for 72 hours to allow time to link to ongoing treatment;
d. Encouraging the development of hospital-based medication initiation protocols that allow for faster dose titrations due to medical monitoring;
e. Advocating for coverage for tailored treatment of opioid use disorder in pregnant patients; and
f. Ensuring linkage to prenatal care as well as addiction treatment (level of care based upon patient need) prior to discharge. ~~with higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing an appropriate amount of naloxone and methadone.~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 502 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 502 be changed to read as follows:

SUPPORT FOR RAPID INPATIENT STABILIZATION AND LINKAGE TO CARE FOR PREGNANT PATIENTS WITH OPIOID USE DISORDER

HOD ACTION: Resolution 502 adopted as amended.

ADOPTED LANGUAGE: SUPPORT FOR RAPID INPATIENT STABILIZATION AND LINKAGE TO CARE FOR PREGNANT PATIENTS WITH OPIOID USE DISORDER

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RESOLVED, that our American Medical Association will advocate for removal of barriers to the development and implementation of pregnancy-specific treatment pathways for pregnant patients with Opioid Use Disorder, including:

a. **Encouraging treatment tailored for pregnancy and the individual patient (i.e. choice of medication, dosage, and frequency of dosing) informed by clinical evaluation, history, available resources, and patient and physician preference;**
b. **Advocating for medication take home flexibilities for pregnant patients;**
c. **Ensuring that institutions have care pathways in place to dispense adequate medication for 72 hours to allow time to link to ongoing treatment;**
d. **Encouraging the development of hospital-based medication initiation protocols that allow for faster dose titrations due to medical monitoring;**
e. **Advocating for coverage for tailored treatment of opioid use disorder in pregnant patients; and**
f. **Ensuring linkage to prenatal care as well as addiction treatment (level of care based upon patient need) prior to discharge.**

RESOLVED, that our American Medical Association will endorse and advocate for implementation of a rapid methadone inpatient stabilization pathway for treatment of Opioid Use Disorder in pregnant patients, with higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing an appropriate amount of naloxone and methadone. (Directive to Take Action)

Your Reference Committee heard supportive testimony for this resolution. Two sections proffered amendments to ensure that all pregnant patients, not just patients being treated with methadone, are included. Additionally, treatment should not rely on one pathway, but multiple pathways. Therefore, Your Reference Committee recommends that Resolution 502 be amended by addition and deletion.

(6) RESOLUTION 505 - AVOIDING MISUSE OF ARTIFICIAL INTELLIGENCE (AI) IN CLINICAL PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends <u>the second Resolve</u> in Resolution 505 be <u>deleted</u>.

~~**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.**~~

RECOMMENDATION B:

<u>RESOLVED, that Policy H-480.931 and Policy H-480.940 be reaffirmed.</u>

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RECOMMENDATION C:
Your Reference Committee recommends that Resolution 505 be adopted as amended.

HOD ACTION: Resolution 505 adopted as amended.

ADOPTED LANGUAGE: 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; and be it further

RESOLVED, that Policy H-480.931 and Policy H-480.940 be reaffirmed.

RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document (New HOD Policy); and be it further

RESOLVED, that any physician or healthcare professional, who chooses to use Artificial Intelligence (AI) in the creation of the medical record, understands that the accuracy of that record is completely the responsibility of that author. (New HOD Policy)

Your Reference Committee heard general support for the first resolved clause and mixed testimony over the second resolved. While there was some support for the second resolved, there were concerns over codifying sole-physician accountability for the accuracy of AI-generated content. Testimony also points out existing AMA policy on this topic as well as ongoing work by CSAPH. There were several recommendations to reaffirm existing policy in lieu of adopting the second resolved. Therefore, your Reference Committee recommends that Resolution 505 be adopted as amended.

(7) RESOLUTION 507 - PAIRING BEHAVIORAL AND LIFESTYLE MEDICINE PRINCIPLES AND PRACTICE WITH GLUCAGON-LIKE PEPTIDE-1 (GLP-1) RECEPTOR AGONISTS AND OTHER ANTI-OBESITY MEDICATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the third Resolve of Resolution 507 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist and other anti-obesity medication therapy, particularly

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for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes, provided that coverage of these medications shall not be conditioned upon participation in such lifestyle intervention programs.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 507 be adopted as amended.

HOD ACTION: Resolution 507 adopted as amended.

ADOPTED LANGUAGE: RESOLVED, that our American Medical Association support, publicize, and advocate for the concomitant use of evidence-based, structured lifestyle and behavioral intervention programs, delivered with ongoing clinician and care-team support, in conjunction with the prescribed use of glucagon-like peptide-1 receptor agonists for obesity and other related, preventable disease states and illnesses; and be it further

RESOLVED, that our AMA recognize and address potential health disparities associated with recommendations for structured lifestyle intervention programs accompanying glucagon-like peptide-1 receptor agonist's therapy, and advocate for equitable access to evidence-based, clinician-supported lifestyle interventions across diverse care settings, including community-based, digital, hybrid, and safety-net models of care; and be it further

RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist and other anti-obesity medication therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes, provided that coverage of these medications shall not be conditioned upon participation in such lifestyle intervention programs.

RESOLVED, that our American Medical Association support, publicize, and advocate for the concomitant use of evidence-based, structured lifestyle and behavioral intervention programs, delivered with ongoing clinician and care-team support, in conjunction with the prescribed use of glucagon-like peptide-1 receptor agonists for obesity and other related, preventable disease states and illnesses (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize and address potential health disparities associated with recommendations for structured lifestyle intervention programs accompanying glucagon-like peptide-1 receptor agonist's therapy, and advocate for equitable access to evidence-based, clinician-supported lifestyle interventions across diverse care settings, including community-based, digital, hybrid, and safety-net models of care (Directive to Take Action); and be it further

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RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist's therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes. (Directive to Take Action)

Your Reference Committee heard testimony strongly supporting a comprehensive, evidence-based approach to obesity care that combines anti-obesity medications with structured lifestyle and behavioral interventions. Speakers consistently emphasized that medications are most effective as an adjunct to nutrition, physical activity, and other health behaviors. There was broad agreement on the need for clinician-supported programs to improve long-term success, alongside concern that inconsistent access to both medications and lifestyle services may worsen disparities, particularly for underserved populations. An amendment was proffered to underscore the importance of equitable coverage and payment models, while cautioning that policies should not unintentionally restrict access to medications by requiring participation in lifestyle programs. Your Reference Committee added other anti-obesity medications to ensure relevancy of this growing medication category. Therefore, your Reference Committee recommends that Resolution 507 be adopted as amended.

(8) RESOLUTION 512 - MEDICAL CANNABIS USE IN OLDER ADULTS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 512 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association support the development and publication of educational resources on ~~medical~~ cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the title of Resolution 512 be changed to read as follows:

CANNABIS USE IN OLDER ADULTS

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 512 be adopted as amended.

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HOD ACTION: Resolution 512 adopted as amended.

ADOPTED LANGUAGE: CANNABIS USE IN OLDER ADULTS

RESOLVED, that our American Medical Association support the development and publication of educational resources on cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks; and be it further

RESOLVED, that our AMA encourage expanded research into the therapeutic uses of cannabis in older adults—such as for managing agitation in individuals with cognitive impairment—as well as its possible adverse effects.

RESOLVED, that our American Medical Association support the development and publication of educational resources on medical cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks (Directive to Take Action); and be it further
RESOLVED, that our AMA encourage expanded research into the therapeutic uses of cannabis in older adults—such as for managing agitation in individuals with cognitive impairment—as well as its possible adverse effects. (New HOD Policy)

Your Reference Committee heard testimony from one section and many individuals that education and information would be helpful for their practice and to advise patients. Edits to the original resolution were made to ensure all cannabis, not just cannabis for medical use is considered. Original Resolved 2 has been retained unchanged. Therefore, Your Reference Committee recommends that Resolution 512 be adopted as amended.

(9) RESOLUTION 513 - ACCESS, AFFORDABILITY, AND SAFETY OF GLP-1 RECEPTOR AGONISTS

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve of Resolution 513 be deleted.

RECOMMENDATION B:

Your Reference Committee recommends that the fourth Resolve of Resolution 513 be amended by addition to read as follows:

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications and risk-benefit analysis, within

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comprehensive care plans that include behavioral and lifestyle interventions.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 513 be amended by addition of a new resolve clause as follows:

RESOLVED that physicians and other prescribers of anti-obesity medications including GLP-1 receptor agonists evaluate individuals for body image concerns, weight history, history of prior and current eating disorders and prior or current treatment for eating disorders before prescribing such medications.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 513 be adopted as amended.

HOD ACTION: Resolution 513 adopted as amended.

ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocate for legislation and/or regulation so that public and private health insurers provide GLP-1 receptor agonists for the treatment of type 2 diabetes and obesity at affordable formulary pricing, thereby reducing out-of-pocket costs for patients; and be it further

RESOLVED, that our AMA advocate for pricing transparency and cost-containment strategies among manufacturers, payers, and policymakers to improve affordability and access to evidence-based obesity and diabetes treatments; and be it further

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications and risk-benefit analysis, within comprehensive care plans that include behavioral and lifestyle interventions.

RESOLVED, that physicians and other prescribers of anti-obesity medications including GLP-1 receptor agonists evaluate individuals for body image concerns, weight history, history of prior and current eating disorders and prior or current treatment for eating disorders before prescribing such medications.

RESOLVED, that our American Medical Association advocate for legislation and/or regulation so that public and private health insurers provide GLP-1 receptor agonists for the treatment of type 2 diabetes and obesity at affordable formulary pricing, thereby reducing out-of-pocket costs for patients (Directive to Take Action); and be it further

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RESOLVED, that our AMA support regulatory oversight and quality-assurance standards for compounding of GLP-1 receptor agonists to promote patient safety while maintaining access for those who cannot otherwise afford FDA-approved medications (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for pricing transparency and cost-containment strategies among manufacturers, payers, and policymakers to improve affordability and access to evidence-based obesity and diabetes treatments (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications, within comprehensive care plans that include behavioral and lifestyle interventions. (New HOD Policy)

Your Reference Committee heard testimony on Resolution 513 that reflected broad, multi-specialty support for advancing policies to improve access, affordability, and safety of GLP-1 receptor agonists, while emphasizing the importance of evidence-based use within comprehensive care. Stakeholders consistently underscored the need to balance patient access with appropriate safeguards, particularly given concerns about cost barriers, inequities in coverage, and safety considerations associated with compounded formulations. During deliberations, amendments were considered and accepted, with clear support coalescing around the amendment incorporating “risk-benefit analysis” into the resolution language to strengthen clinical decision-making and patient counseling. One Council and a delegation advocated for the deletion of the second resolve, noting concerns around nefarious compounding practices outside of FDA approved regulations, which places patient safety at significant risk. Multiple amendments were proffered related to body image and eating disorder risks with GLP-1 use. Your Reference Committee further refined the language to highlight the importance of this consideration without being overly prescriptive. By using ‘evaluate’ to ensure continued individualized practice, clinician awareness and appropriate assessment without imposing rigid requirements that could limit access. Additionally, an amendment was proposed to add anti-obesity medications to ensure relevancy of this growing medication category and number of indications for use beyond obesity. Your Reference Committee recommends Resolution 513 be adopted as amended.

(10) RESOLUTION 515 - TRANSPARENCY IN AI-DRIVEN ADVERSE DETERMINATIONS & CLINICAL LOGIC DISCLOSURE

RECOMMENDATION A:

Your Reference Committee recommends that <u>the first Resolve</u> of Resolution 515 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association (AMA) advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians <u>and the insured patient</u> with the specific clinical logic, evidence-based sources, and

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version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination; and be it further

RECOMMENDATION B:

Your Reference Committee recommends the second Resolve of Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited, with re-audits triggered by material changes to the AI model, its training data, or applicable clinical guidelines, and with periodic comprehensive audits at minimum annually regardless of such changes, to ensure it reflects ~~the most recent~~ current ~~peer-reviewed~~ evidence-based clinical guidelines and recognized standards of care.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 515 be adopted as amended.

HOD ACTION: Resolution 515 adopted as amended.

ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians and the insured patient 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; and be it further

RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited with re-audits triggered by material changes to the AI model, its training data, or applicable clinical guidelines, and with periodic comprehensive audits at minimum annually regardless of such changes, to ensure it reflects current evidence-based clinical guidelines and recognized standards of care.

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

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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)

Your Reference Committee heard supportive testimony on this resolution along with suggested amendments to both resolves. The amendment proffered for the first resolve added the insured patient as a party that must be provided with information on AI tools used in the issuance of an adverse determination. The amendment proffered for the second resolve defined audit frequency and received testimony in support. Therefore, your Reference Committee recommends that Resolution 515 be adopted as amended.

(11) RESOLUTION 516 – FDA REGULATION OF UNAPPROVED SYNTHETIC PEPTIDES

RECOMMENDATION A:

Your Reference Committee recommends that first Resolve of Resolution 516 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) ~~supports appropriate FDA oversight of synthetic peptides~~, recommend~~s~~ing that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that second Resolve of Resolution 516 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 516 be adopted as amended.

HOD ACTION: Resolution 516 be adopted as amended.

ADOPTED LANGUAGE: RESOLVED, that our American Medical Association (AMA), recommends that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use; and be it further

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RESOLVED, that our American Medical Association (AMA) supports appropriate FDA oversight of synthetic peptides, recommending that unapproved synthetic peptide products undergo regulatory review, third-party testing, and demonstration of safety and

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efficacy through well-conducted clinical trials before marketing or clinical use; and be it further

RESOLVED, that our AMA submit comments to the Food and Drug Administration (FDA) regarding the July 2026 Pharmacy Compounding Advisory Committee review of synthetic peptide products, advocating for evidence-based regulatory oversight, third-party testing, and demonstration of safety and efficacy prior to marketing, compounding, or clinical use.

Your Reference Committee heard mixed in-person testimony on this resolution. One delegation and one individual testified in support that this area is moving quickly and stating that unregulated peptides expose patients to safety risks due to variable sourcing and standards, as well as a lack of safeguards. There was also testimony requesting referral for decision due to urgency of the resolution given the upcoming July 2026 FDA Pharmacy Compounding Committee meeting. However, even Referral for Decision would not allow for an official Board review and decision prior to submission of official comments by the July 9, 2026 deadline. Another delegation called for Referral for Study, noting that more study is also needed to better understand these products before an official comment. Therefore, the Reference Committee recommends that Resolution 516 be referred.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(12) RESOLUTION 506 - ACCESS TO GENDER AFFIRMING HEALTHCARE INCLUDING CLINICAL TRIALS
RESOLUTION 509 - PRESERVING GENDER-AFFIRMING SURGICAL CARE ACCESS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 509 be adopted in lieu of Resolutions 506 and 509.

GENDER AFFIRMING HEALTHCARE AND RESEARCH

RESOLVED, that our American Medical Association affirms that gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians, when applicable; and be it further

RESOLVED, that our AMA advocate and support new and restored funding, as well as opportunities for GAHC research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity; and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making GAHC.

HOD ACTION: Alternate Resolution 509 be adopted in lieu of Resolutions 506 and 509.

ADOPTED LANGUAGE: GENDER AFFIRMING HEALTHCARE AND RESEARCH

RESOLVED, that our American Medical Association affirms that gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians, when applicable; and be it further

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RESOLVED, that our AMA advocate and support new and restored funding, as well as opportunities for GAHC research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity; and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making GAHC.

RESOLUTION 506 - ACCESS TO GENDER AFFIRMING HEALTHCARE INCLUDING CLINICAL TRIALS

RESOLVED, that our American Medical Association affirms that Gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians (New HOD Policy); and be it further

RESOLVED, that our AMA calls for continued research including clinical trials regarding the evidence of the effectiveness of puberty blockers (GnRH analogs) on transgender and non-binary youth (New HOD Policy); and be it further
RESOLVED, that our AMA calls for the restoration of previously allocated federal, state and institutional funding for pediatric gender clinics, puberty blocker research protocols, and supportive mental health services. (New HOD Policy)

RESOLUTION 509 - PRESERVING GENDER-AFFIRMING SURGICAL CARE ACCESS

RESOLVED, that our American Medical Association reaffirm and recognize that decisions regarding gender-affirming surgical care rest with physicians, patients, and families, and support evidence-based, patient-centered, shared decision-making for such care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate and support funding and opportunities for gender-affirming care research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making gender-affirming surgical and medical care. (Directive to Take Action)

Your Reference Committee heard online testimony on gender-affirming care across Resolutions 506 and 509 reflecting a deeply engaged medical community balancing patient access, clinical evidence, and ethical responsibility. Across specialties and

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delegations, a central theme emerged that gender-affirming care is understood as a multidisciplinary, patient-centered process that may include social, medical, and, in some cases, surgical interventions, with decisions grounded in shared decision-making among patients, families, and physicians. Supporters consistently emphasize that access to this care is both medically necessary and ethically grounded, particularly for a vulnerable population facing significant health disparities. They argue that restricting access, whether through loss of funding, legislative action, or structural barriers, has tangible harms, including worsened mental health outcomes, delayed care, and increased inequities. A strong call for continued research unites nearly all testimony, though motivations differ. Supporters advocate for expanded funding, clinical trials, and longitudinal studies to strengthen the scientific foundation of care and ensure decisions remain evidence-based and patient-centered, stressing gaps in evidence should prompt further study and not justify restricting treatment. At the same time, opposing voices raise concerns about the current strength and consistency of the evidence, particularly for pediatric populations. They highlight uncertainties about long-term outcomes, potential harms, and ethical challenges in obtaining informed consent for irreversible interventions in minors. Some cite emerging international policy shifts and systematic reviews as reasons for caution and for prioritizing more rigorous, ethically designed research before expanding access. Despite differing views, there is broad agreement on the need for rigorous, ethical research and individualized clinical care. The Reference Committee ultimately reflected these themes in an alternate resolution emphasizing evolving evidence, the importance of continued research, and ongoing collaboration across specialties.

During the in-person meeting, we continued to hear deeply engaged testimony on Alternate Resolution 509. Testimony on Alternate Resolution 509 overwhelmingly supported the Preliminary Report language, noting the appropriate emphasis on the sanctity of the patient-physician relationship in decision-making of all aspects of gender-affirming care. Further, testimony appreciated that this alternate resolution did not dictate an age related to gender-affirming care, but instead simply focused on preserving access to care. In dissenting testimony, one delegation noted the limited amount of evidence and the potential for harm, considering this may be an area that our AMA does not dictate care. However, multiple delegations countered that limited evidence is not the same as no evidence and that clinical studies in this field typically include very few patients and the current alternate resolution allows physicians to maintain decisions related to care between the physician and the patient. One amendment was proffered regarding not only supporting funding, but also restoring funding, with a focus on pediatric gender-affirming care and mental health services. Your Reference Committee noted that restoring funding would be a prudent addition to the resolution, but that specification of ages and types of care are already included in the language without being prescriptive. Therefore, your Reference Committee recommends Alternate Resolution 509 be adopted in lieu of Resolution 506 and Resolution 509.

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(13) RESOLUTION 511 - PRESERVING SPECIALTY ACCESS TO ANTI-CANCER AGENTS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 511 be adopted in lieu of Resolution 511.

PRESERVING SPECIALTY ACCESS TO ANTI-CANCER MEDICATIONS

RESOLVED, that our AMA support multidisciplinary, evidence-based cancer care models and oppose single-specialty restrictions on physician prescribing and/or administering anti-cancer medications when their use falls within the physician's education, training and clinical practice and institutional safety and infrastructure standards are met; and be it further

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of anti-cancer medications; and be it further

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer medications based solely on specialty designation rather than clinical competency, training, and patient need.

HOD ACTION: Alternate Resolution 511 be adopted in lieu of Resolution 511.

ADOPTED LANGUAGE: PRESERVING SPECIALTY ACCESS TO ANTI-CANCER MEDICATIONS

RESOLVED, that our AMA support multidisciplinary, evidence-based cancer care models and oppose single-specialty restrictions on physician prescribing and/or administering anti-cancer medications when their use falls within the physician's education, training and clinical practice and institutional safety and infrastructure standards are met; and be it further

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of anti-cancer medications; and be it further

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer medications based solely on specialty designation rather than clinical competency, training, and patient need

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RESOLVED, that our American Medical Association support multidisciplinary, evidence-based cancer care models and oppose categorical specialty-based restrictions on physician prescribing and/or administering anti-cancer agents when the physician is appropriately trained in their use and institutional safety standards are met (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of chemotherapeutic and other anti-cancer agents (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer agents based solely on specialty designation rather than clinical competency, training, and patient need. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this resolution. There was both support for the appropriate utilization of anti-cancer medications by physicians other than oncology specialists, as well as concern for appropriate training and potential scope creep. Further, an amendment for adjusted language related to agents versus medications was noted. Authors proffered an additional amendment to the first resolve in response to concerns voiced in the testimony. Therefore, your Reference Committee recommended adopting Alternative Resolution 511 in lieu of Resolution 511.

(14) RESOLUTION 514 - EDUCATION, SCREENING, AND EFFECTIVE TREATMENT FOR OBSTRUCTIVE SLEEP APNEA DURING PREGNANCY

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 514 be adopted in lieu of Resolution 514.

OBSTRUCTIVE SLEEP APNEA DURING PREGNANCY

RESOLVED, that our AMA recognizes the potential negative outcomes of obstructive sleep apnea in pregnancy and supports education and training of physicians to engage patients about the potential impacts; and be it further

RESOLVED, that our AMA encourage continued research on the impact of obstructive sleep apnea on pregnancy and adverse pregnancy outcomes; and be it further

RESOLVED, that our AMA support insurance coverage and physician payment for screening and treatment of obstructive sleep apnea in pregnancy.

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HOD ACTION: Alternate Resolution 514 be adopted in lieu of Resolution 514.

ADOPTED LANGUAGE: OBSTRUCTIVE SLEEP APNEA DURING PREGNANCY

RESOLVED, that our AMA recognizes the potential negative outcomes of obstructive sleep apnea in pregnancy and supports education and training of physicians to engage patients about the potential impacts; and be it further

RESOLVED, that our AMA encourage continued research on the impact of obstructive sleep apnea on pregnancy and adverse pregnancy outcomes; and be it further

RESOLVED, that our AMA support insurance coverage and physician payment for screening and treatment of obstructive sleep apnea in pregnancy.

RESOLVED, that our American Medical Association adopt policy to screening and educating about obstructive sleep apnea:

That AMA supports obstructive sleep apnea screening to reduce negative outcomes

That AMA supports physician payment for obstructive sleep apnea screening and treatment.

That AMA advocates for more research on obstructive sleep apnea in pregnancy.

That AMA supports education about obstructive sleep apnea in pregnancy.
(New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation aligning with this policy. Routine screening, early diagnosis, and effective treatment of obstructive sleep apnea are recommended in pregnant women, particularly during mid and late pregnancy. (Directive to Take Action)

Your Reference Committee heard supportive testimony on the basis of this resolution. However, there were multiple distinct amendments offered. The first amendment, proposed substitution of three resolves to emphasize the importance of research, education, and insurance coverage of obstructive sleep apnea in pregnant individuals. This was supported by one delegation. Two other amendments advocated for removing “routine screening” and “particularly during mid and late pregnancy.” from the second resolve due to challenges to the current landscape and risks of waiting for screening. Neither of these amendments garnered support. Given the strong support for the sentiment, coupled with existing AMA policy that addresses education, screening, and treatment of obstructive sleep apnea in the general population, your Reference Committee recommends adopting Alternate Resolution 514 in lieu of Resolution 514.

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RECOMMENDED FOR REFERRAL

(15) RESOLUTION 508 - ALIGNING CONSISTENCY AND CREDIBILITY OF DIRECT-TO-CONSUMER GUT MICROBIOME TESTING SERVICES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 508 be referred.

HOD ACTION: Resolution 508 be referred.

RESOLVED, that our American Medical Association develop policy that specifically addresses concerns about the design, use and oversight of commercial gut microbiome testing methods with regards to quality, reliability and reproducibility of results and assessments provided to lay consumers, upon which such consumers prognosticate informed decisions regarding their health status and subsequent health care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for review and graded recommendation by the United States Preventive Services Task Force on the use of Direct-to-Consumer Gut Microbiome Testing Services with regard to quality, reliability, reproducibility and validity (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Consumer Protection Agency to establish transparent safe guards and evidence-based, scientific oversight of Direct-to-Consumer Gut Microbiome Testing Services for lay and professional clinical use. (Directive to Take Action)

Your Reference Committee heard strong support from multiple sections and delegations for the basis of the resolution on the need for oversight of gut microbiome testing. Notably, testimony suggested referral for study noting the need for continued evaluation of the emerging evidence about microbiome testing in the context of patient care, the need for more guidance for physicians on how to discuss the limitations of direct-to-consumer microbiome testing with patients; and also noting that the regulatory bodies for these tests is unclear and potentially nonexistent and misrepresented in the current resolution. Resolution authors agreed with this need for further investigation. Therefore, your Reference Committee recommends Resolution 508 be referred.

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(16) RESOLUTION 510 - EXOSOME AND PEPTIDE USE IN HEALTHCARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 510 be referred.

HOD ACTION: Resolution 510 be referred.

RESOLVED, that our AMA take the lead in advising Congress, the FDA and our regulatory agencies in:
1) Categorizing Exosomes and Peptides by their longevity, wound healing and regenerative potentials.

2) Encouraging the manufacture and processing of Exosomes and Peptides in the United States.

3) Work with the FDA to properly reclassify Exosomes and Peptides to allow Physicians to order and dispense Exosomes and Peptides properly sourced from FDA-approved pharmacies to patients to treat appropriate patient medical concerns including wound healing, improved health and longevity.

4) Work to advise Congress to propose an amendment to the NDAA for FY2027 that addresses appropriate use of Exosomes and Peptides within the Armed Services and VA system to improve Soldier and Veteran Healthcare, especially in acute and chronic wound healing.

5) Encourage additional trials and testing of Exosome and Peptide use protocols to firmly establish their efficacy as necessary.

6) Refer this issue to the AMA Council on Science and Public Health for study and report back at Interim 2026 due to the urgency of passing an amendment to the NDAA for FY2027.

Your Reference Committee primarily heard mixed testimony on this resolution. Online testimony emphasized that peptides and exosomes are broad classes of biological products that are characterized by a lack of research and inconsistent terminology, opposing this resolution’s broad characterization. Online testimony also included several calls for referral to better understand this emerging group of agents. Therefore, the Reference Committee recommends that Resolution 510 be referred.

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(17) RESOLUTION 503 - EXPANSION OF PSYCHEDELIC ASSISTED THERAPY (PAT)

RECOMMENDATION:

Your Reference Committee recommends that Policy H-120.917 and Policy H-100.943 be reaffirmed in lieu of Resolution 503.

HOD ACTION: Your Reference Committee recommends that Policy H-120.917 and Policy H-100.943 be reaffirmed in lieu of Resolution 503.

RESOLVED, that our American Medical Association reaffirm policies H-120.917 and H-100.943. (Reaffirm HOD Policy)

Your Reference Committee heard limited testimony for this resolution. Resolution authors recommend policies be reaffirmed. Therefore, your Reference Committee recommends that existing policies H-120.917 and H-100.943 be reaffirmed in lieu of Resolution 503.

(18) RESOLUTION 504 - STRENGTHENING U.S. RUBBER GLOVE PRODUCTION AND PURCHASE WHILE REDUCING FOREIGN FORCED-LABOR DEPENDENCE

RECOMMENDATION:

Your Reference Committee recommends that Policy H-440.847 and Policy H-100.956 be reaffirmed in lieu of Resolution 504.

HOD ACTION: Your Reference Committee recommends that Policy H-440.847 and Policy H-100.956 be reaffirmed in lieu of Resolution 504.

RESOLVED, that our American Medical Association advocate with the appropriate Federal agencies to prioritize production and procurement of domestically manufactured rubber gloves and their component materials consistent with the Buy American Act (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage health care systems, physicians and other health care professionals, and affiliated entities to source rubber gloves from U.S. manufacturers whenever feasible, with preference for products whose raw materials originate within the domestic supply chain (New HOD Policy); and be it further

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RESOLVED, that our AMA promote rigorous supply chain transparency by urging federal regulators and relevant authorities to strengthen import enforcement, enhance due-diligence requirements, and conduct independent audits to ensure that imported rubber gloves meet appropriate ethical labor standards. (Directive to Take Action)

Your reference committee heard testimony in opposition to Resolution 504 as written. Testimony emphasized the importance of ethical labor practices and supply chain transparency. However, it was noted that this resolution may reduce access to high-quality medical products and reduce supply chain flexibility. It was pointed out there is not significant domestic production of raw rubber material. Further, it was noted our AMA has significant drug shortages and supply chain policy from the annual CSAPH report. Therefore, your Reference Committee recommends that these policies be reaffirmed in lieu of Resolution 504.

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This concludes the report of Reference Committee E. I would like to thank Kevin Bernstein, MD, Thomas Peters, MD, Maria Phillis, MD, Sharmini Rasakulasuriar, MD, Natalia Solenkova, MD, Joel Dumonsau, and all those who testified before the Committee, as well as our AMA staff Jane Sachs, Jennie Jarrett, Julia Mouat, and Nikki Carter.

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American Academy of Family Physicians

Sharmini Rasakulasuriar, MD
Iowa

Thomas Peters, MD
Florida

Natalia Solenkova, MD, PhD, MLS (Alternate)
Florida

Maria Phillis, MD, JD (Alternate)
Ohio

Joel Dumonsau (Alternate)
Regional Medical Student

Raymond Lorenzoni, MD
Connecticut (Alternate)
Chair

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DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Report of Reference Committee on Ethics and Bylaws

Carlos Latorre, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 35 - Specialty Society Representation in the House of Delegates – Five-Year Review
3. CCB Report 02 - HOD Representation and Composition
4. CCB Report 04 - Credentialing of HOD Delegates and Alternate Delegates
5. CCB Report 05 - Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
6. CCB Report 06 - Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
7. CCB Report 07 - HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
8. CCB Report 08 - Business Meetings of the AMA Sections
9. CCB Report 09 - Continuity of AMA Resident and Fellow Section Governing Council Leadership
10. CEJA 02 - Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
11. CEJA 05 - CEJA's Sunset Review of 2016 House Policies
12. Resolution 001 - Ethical Guidance on Postmortem Sample Collection for Genetic Testing
13. Resolution 003 - Artificial Intelligence to Bolster Physician-Led Team-Based Care
14. Resolution 008 - Senior Physicians Improving Patient Access
15. Resolution 009 - Preserving Access to Care for Undocumented Individuals
16. Resolution 011 - Physician Ability to Render Emergency Medical Aid During Immigration Enforcement

RECOMMENDED FOR ADOPTION AS AMENDED

17. CCB Report 03 - Rights & Privileges of HOD Members
18. Resolution 002 - Physician Workload and Scheduling
19. Resolution 004 - Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
20. Resolution 005 - Impersonation of a Physician
21. Resolution 007 - Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software

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22. Resolution 010 - Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

RECOMMENDED FOR REFERRAL

23. CEJA 01- Guidelines on Chaperones for Sensitive Exams
24. CEJA 03 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

RECOMMENDED FOR NOT ADOPTION

25. Resolution 006 - Investigating Moral Injury Related to Organ Procurement Practices
26. Resolution 012 - Taking Action on Deaths in Custody

RECOMMENDED FOR FILING

27. BOT Report 36 - Update on the Report of the TRHT Task Force to the AMA Board of Trustees

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RECOMMENDED FOR ADOPTION

(1) BOT REPORT 02 - NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 02 adopted and the remainder of the report filed.

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

Limited online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(2) BOT REPORT 35 - SPECIALITY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 35 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 35 be adopted and the remainder of the report be filed.

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

1. The American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Post-Acute and Long-Term Care Medical Association, Renal Physicians Association, Society of Critical Care Medicine, and Society of Interventional Radiology

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retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Association of Physicians of Indian Origin and American Society of Cataract and Refractive Surgery be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Vein and Lymphatic Society lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current 5 guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2. (Directive to Take Action)

Minimal in-person testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(3) CCB REPORT 02 - HOD REPRESENTATION AND COMPOSITION

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 02 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

2—House of Delegates

2.0.1 Composition and Representation. ***

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

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

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

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

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

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

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

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

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

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

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

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

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

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state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

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

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

***

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

***

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

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

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each

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organization of the number of seats in the House of Delegates to which it is entitled during the current year.

***

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

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

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

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

2—House of Delegates

2.0.1 Composition and Representation. ***

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

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

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

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

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

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d. Representation of the AMA and the House of Delegates to physicians, medical associations, and others, including resident and fellow physicians and medical students.
e. Solicitation of input from and provision of feedback to constituents.

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

***

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

~~**2.10.7**~~
2.0.1.4 Unique Representation. No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

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

~~**2.0.1.3**~~
2.0.1.6 Autonomy. The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

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

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

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

***

2.1.4 Term. Delegates and alternate delegates from constituent associations shall be selected for two ~~2~~-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate

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delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.
***
2.2 National Medical Specialty Societyies Delegations. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 using methods specified in AMA policy.
2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate and alternate delegate for each 1,000, or fraction thereof, physician specialty society members, including residents and fellows, as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA.
2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. **2.10.1. Notification.** In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.
***
2.2.4 Term. Delegates and alternate delegates from specialty societies shall be selected for two 2-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate and alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.
***
2.6 Other Delegates and Alternate Delegates. Each of the following is entitled to a delegate and an alternate delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.
***
2.6.2 Term. Delegates and alternate delegates from these entities shall be selected for two 2-year terms, and shall assume office on the date set by the entity. ***
(Modify Bylaws)

Online testimony was in near unanimous support. An amendment was proffered to revise 2.0.1.1 for clarity and to delete 2.1.4 and 2.2.4 in their entirety. The authors noted that the Council proposed deleting reference to the "2-year term" at I-25, but the proposed deletion was rejected at that meeting. Your Reference Committee recommends that the report be adopted.

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(4) CCB REPORT 04 - CREDENTIALING OF HOD DELEGATES AND ALTERNATE DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 04 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 04 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

***

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

***

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

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2.4.4 Credentialing. The chair of the Resident and Fellow Section Governing Council or the director of the Resident and Fellow Section, or their designee, shall provide the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3. Credentialing of delegates and alternate delegates must occur at least 45

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days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

***

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

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

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

***

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

***

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

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

***

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

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

Online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(5) CCB REPORT 05 - INCLUSION OF MEDICAL STUDENTS AND RESIDENT/FELLOW PHYSICIANS IN HOD DELEGATIONS

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 05 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 52 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

****

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

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

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

****

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

****

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

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

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

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2.6 Other Delegates. ***

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2.6.2 Term. ***

2.6.2.1 Resident/Fellow Physician and Medical Student Delegates. These entities may designate their delegate and/or alternate delegate seat to be CCB Rep. 5-A-26 -- page 4 of 4 filled by a resident/fellow physician member or a medical student member.

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

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

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delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

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

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

***

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

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

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

***

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

***

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

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

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

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2.6 Other Delegates. ***

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2.6.2 Term. ***

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

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

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

(Modify Bylaws)

Online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

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(6) CCB REPORT 06 - MEDICAL STUDENT REGIONAL DELEGATES AND ALTERNATE DELEGATES AND RESIDENT AND FELLOW SECTIONAL DELEGATES AND ALTERNATE DELEGATES IN THE HOD

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 06 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 06 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

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

2.3.2.1 Effective Date. In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council and the Director of the Medical Student Section of the number

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of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

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

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

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

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

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

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

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

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Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

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

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

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

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

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

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

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

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

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

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

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

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

2.4.1 Qualifications. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ must be active members of the

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

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

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

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

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

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~~**2.10.9**~~

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

Online testimony was in unanimous support. One amendment was proffered to clarify language in 2.3.3; your Reference Committee notes, however, that "rules" is consistent terminology throughout the Constitution and Bylaws. Your Reference Committee recommends that the report be adopted.

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(7) CCB REPORT 07- HOD DELEGATE AND ALTERNATE DELEGATE VACANCIES AND MEETING ABSENCES

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 07 be adopted and remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 07 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

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

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

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

2.10 Temporary Delegates and Alternate Delegates.

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

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

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

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

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

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

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

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

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

2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate. The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and

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fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

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

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

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

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

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

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

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

~~2.10.4 Substitute Delegates.~~
2.10.1 Temporary Delegates. The credentialing authority of any entity represented in the House of Delegates may credential a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

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

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

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

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

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

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

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

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

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

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

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

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

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~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~
(Modify Bylaws)

Online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(8) CCB REPORT 08 - BUSINESS MEETINGS OF THE AMA SECTIONS

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 08 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 08 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

7.0.6.1.1 To hear such reports as may be appropriate.

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

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

7.0.6.1.4 To hold elections.

7.0.6.2 Meeting Procedure.

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

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

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

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

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

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

7.0.6.1.1 To hear such reports as may be appropriate.

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

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

7.0.6.1.4 To hold elections.

7.0.6.2 Meeting Procedure.

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

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

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

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Online testimony was in unanimous support. An amendment was proffered to change language in 7.0.6.1 from “the Business Meeting” to “a Business Meeting”. The authors noted that this language was discussed and that while AMA Sections must have "a" Business Meeting, this language does not preclude AMA Sections from conducting additional meetings. Your Reference Committee recommends that the report be adopted.

(9) CCB REPORT 09 - CONTINUITY OF AMA RESIDENT AND FELLOW SECTION GOVERNING COUNCIL LEADERSHIP

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 09 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 09 adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

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

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

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

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

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

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

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.
7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:
a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education.
b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

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

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

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

(Modify Bylaws)

Online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(10) CEJA REPORT 02 - MANAGING CONFLICT OF INTEREST INHERENT IN NEW PAYMENT MODELS—PATIENT DISCLOSURE

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA Report 02 adopted and the remainder of the report filed.

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

Online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

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(11) CEJA REPORT 05 - CEJA'S SUNSET REVIEW OF 2016 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 05 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA Report 05 adopted and the remainder of the report filed.

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Limited online testimony was in unanimous support. Your Reference Committee recommends that the report be adopted.

(12) RESOLUTION 001 - ETHICAL GUIDANCE ON POSTMORTEM SAMPLE COLLECTION FOR GENETIC TESTING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 001 be adopted.

HOD ACTION: Resolution 001 adopted.

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

Online testimony was in unanimous support. Your Reference Committee recommends the resolution be adopted.

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(13) RESOLUTION 003 - ARTIFICIAL INTELLIGENCE TO BOLSTER PHYSICIAN-LED TEAM-BASED CARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 003 be adopted.

HOD ACTION: Resolution 003 adopted.

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

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

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

Online testimony was in unanimous support. An amendment to the first resolve clause was proffered to explicitly call out the physician-led framework reflected in the remainder of the resolution; however, your Reference Committee believes this would unintentionally have a limiting effect on the directive. Testimony requested report back at the I-26 meeting due to the urgency of the matter. Your Reference Committee recommends the report be adopted.

(14) RESOLUTION 008 - SENIOR PHYSICIANS IMPROVING PATIENT ACCESS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 008 be adopted.

HOD ACTION: Resolution 008 adopted.

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

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

Online testimony was in unanimous support. Your Reference Committee recommends the resolution be adopted.

(15) RESOLUTION 009 - PRESERVING ACCESS TO CARE FOR UNDOCUMENTED INDIVIDUALS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be adopted.

HOD ACTION: Resolution 009 adopted.

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

Online testimony was in unanimous support. Your Reference Committee recommends that the resolution be adopted.

(16) RESOLUTION 011 - PHYSICIAN ABILITY TO RENDER EMERGENCY MEDICAL AID DURING IMMIGRATION ENFORCEMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 011 be adopted.

HOD ACTION: Resolution 011 adopted.

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RESOLVED, that our American Medical Association study the ethical responsibilities of physicians to render emergency medical care as bystanders when such care is obstructed for patients in legal custody, including immigration enforcement activities

In-person testimony was in near unanimous support. Your Reference Committee recommends that the resolution be adopted.

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RECOMMENDATION FOR ADOPTION AS AMENDED

(17) CCB REPORT 03 - RIGHTS & PRIVILEGES OF HOD MEMBERS

RECOMMENDATION A:

Your Reference Committee recommends that section 2.0.1.3.2 of CCB Report 03 be amended by addition as follows:

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

RECOMMENDATION B:

That CCB Report 03 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 02 adopted as amended and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

2.0.1.2 Representation. *

2.0.1.3 Alternate Delegates. *

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

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

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

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

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2.8 Additional Alternate Delegates.

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

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

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

2—House of Delegates

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

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

2.0.1.2 Representation. ***

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

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

2.0.1.3.2 Alternate Delegate Seated for a Delegate. ~~**2.8.5**~~ At the request of their corresponding delegate, ~~A~~an alternate delegate may be seated for them ~~substitute for a delegate,~~ on the floor of the House of Delegates~~, at the request of the delegate by~~

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

~~**2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of the entity they represent.~~
~~**2.8.2 Certification.** Alternate delegates shall be certified to the AMA in the same manner as delegates.~~
~~**2.8.3 Term.** Alternate delegates shall be selected for a 2-year term, and shall assume office on the date set by the organization, unless otherwise provided in these Bylaws.~~
~~**2.8.4 Vacancies.** Alternate delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that term.~~

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

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

***

2.8 Additional Alternate Delegates.

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

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

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Online testimony was in strong support of amending the report. An amendment was proffered to move 2.0.1 to a new 2.11.2 titled “Rights and Privileges” (and renumber accordingly). A clarifying amendment was proffered to change “corresponding delegate” to “corresponding delegation” in the first sentence of 2.0.1.3.2, and revise the remainder of the sentence to read: “an alternate delegate may be seated for a delegate.” Another amendment was proffered to amend 2.0.1.3.2 by deletion to remove reference to “salmon badge” to allow more flexibility to change the temporary credentials in the future without a Bylaws change. The authors noted that the term "Salmon Badge" has been widely used and accepted for many years, that the Council has considered the "Delegation" versus "Delegate" language, and continues to recommend the language and order as written. Your Reference Committee recommends that the report be adopted as amended.

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(18) RESOLUTION 002 - PHYSICIAN WORKLOAD AND SCHEDULING

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association ~~adopt policy~~ affirm~~ing~~ that physicians have the ethical duty, professional right and authority, notwithstanding extraordinary situations such as mass casualty incidents and disasters, to decline, modify, or limit administratively determined patient volume- expectations, scheduling mandates, and staffing conditions when the physician feels these ~~that~~ conditions would harm patients or negatively impact ~~compromise patient safety or their ability to provide safe, thorough, and~~ patient-centered care. (New HOD Policy)

RECOMMENDATION B:

That Resolution 002 be adopted as amended.

HOD ACTION: First resolve clause in Resolution 002 amended by addition and deletion as follows:

RESOLVED, that our American Medical Association ~~adopt policy~~ affirm~~ing~~ that physicians have the ~~ethical duty,~~ professional right and authority, notwithstanding extraordinary situations such as mass casualty incidents and disasters, to decline, modify, or limit administratively determined patient volume-expectations, scheduling mandates, and staffing conditions when the physician, utilizing clinical judgment, believes ~~feels~~ these ~~that~~ conditions would harm patients or negatively impact ~~compromise patient safety or their ability to provide safe, thorough, and~~ patient-centered care. (New HOD Policy)

Resolution 002 adopted as amended.

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ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association affirm that physicians have the professional right and authority, notwithstanding extraordinary situations such as mass casualty incidents and disasters, to decline, modify, or limit administratively determined patient volume expectations, scheduling mandates, and staffing conditions when the physician, utilizing clinical judgment, believes these conditions would harm patients or negatively impact patient-centered care. (New HOD Policy)

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

RESOLVED, that our AMA advocate for and support state and federal legislation or regulation that ensures local practicing physicians direct and control the development and implementation of patient scheduling protocols, workload standards, patient panel limits, and clinical staffing models within their practices and health systems, based on clinical complexity, time required for direct and indirect care, and safe practice standards rather than productivity or revenue targets. (Directive to Take Action)

Online testimony was in strong support. In-person testimony was in unanimous support of an amendment proffered by the authors. Your Reference Committee recommends that the resolution be adopted as amended.

(19) RESOLUTION 004 - ETHICAL REPRODUCTIVE CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

RECOMMENDATION A:

Your Reference Committee recommends that the recommended addition to Policy H-215.981 in the second resolve clause be amended by addition and deletion as follows:

> d. Clinicians to obtain direct, task-specific informed consent from individuals with intellectual and developmental disabilities, ~~IDD~~, including discussing genetic diagnoses, ~~—~~whenever they demonstrate capacity for the decision at hand and, when legally required, the consent of a guardian or other authorized decision-maker.

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RECOMMENDATION B:

That the third resolve clause of Resolution 004 be amended by addition and deletion as follows:

RESOLVED, that our AMA support clinician education on disability-competent reproductive care, including accessible communication strategies, historical context, and best practices for ethical contraceptive counseling for individuals with intellectual and developmental disabilities ~~IDD~~.

RECOMMENDATION C:

That Resolution 004 be adopted as amended.

HOD ACTION: Resolution 004 adopted as amended.

ADOPTED LANGUAGE:

d. Clinicians to obtain direct, task-specific informed consent from individuals with intellectual and developmental disabilities, including discussing genetic diagnoses, whenever they demonstrate capacity for the decision at hand and, when legally required, the consent of a guardian or other authorized decision-maker.

RESOLVED, that our AMA support clinician education on disability-competent reproductive care, including accessible communication strategies, historical context, and best practices for ethical contraceptive counseling for individuals with intellectual and developmental disabilities.

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

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

1. Our American Medical Association encourages:

a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.

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b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.

c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.

d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.

f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.

g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.

2. Our AMA seeks:
a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.

b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.

3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:

a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.

b. An individual’s medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

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4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that

a. incorporates critical disability studies.

b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:

a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.

b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.

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c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

d. Clinicians to obtain direct, task-specific informed consent from individuals with IDD whenever they demonstrate capacity for the decision at hand and, when legally required, the consent of a guardian or other authorized decision-maker.

(Modify Current HOD Policy); and be it further

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

Online testimony was in universal support. Two amendments were proffered, which the authors noted as consistent with the intent of the resolution. Your Reference Committee recommends that the resolution be adopted as amended.

(20) RESOLUTION 005 - IMPERSONATION OF A PHYSICIAN

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 005 be amended by deletion as follows:

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

RECOMMENDATION B:

That Resolution 005 be amended by the addition of a second resolve clause as follows:

RESOLVED, that our AMA support the creation and enforcement of state laws prohibiting physician impersonation; (New HOD Policy)

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RECOMMENDATION C:

That Resolution 005 be amended by the addition of a third resolve clause as follows:

RESOLVED, that our AMA encourage the development of clear public reporting mechanisms and collaboration among medical boards, law enforcement, and legislative bodies to ensure accurate identification and record of physician impersonation and effective, enforceable consequences; (New HOD Policy)

RECOMMENDATION D:

That Resolution 005 be amended by the addition of a fourth resolve clause as follows:

RESOLVED, that our AMA promote improved coordination among regulatory bodies to prevent and address impersonation of licensed physicians. (New HOD Policy)

RECOMMENDATION E:

That Resolution 005 be adopted as amended.

HOD ACTION: Resolution 005 adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association recognizes physician impersonation as a significant threat to public health and patient safety; (New HOD Policy)

RESOLVED, that our AMA support the creation and enforcement of state laws prohibiting physician impersonation; (New HOD Policy)

RESOLVED, that our AMA encourage the development of clear public reporting mechanisms and collaboration among medical boards, law enforcement, and legislative bodies to ensure accurate identification and record of physician impersonation and effective, enforceable consequences; (New HOD Policy)

RESOLVED, that our AMA promote improved coordination among regulatory bodies to prevent and address impersonation of licensed physicians. (New HOD Policy)

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

Online testimony was in unanimous support. An amendment was proffered to address the fact that medical boards regulate licensed physicians and do not have jurisdiction to discipline individuals who are not licensed. Your Reference Committee recommends separating the resolve clause for clarity and that the resolution be adopted as amended.

(21) RESOLUTION 007 - SUPPORTING PRIVACY IN THE USE OF ARTIFICIAL INTELLIGENCE BASED SCRIBE SOFTWARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 007 be amended by deletion as follows:

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

RECOMMENDATION B:

That Resolution 007 be adopted as amended.

HOD ACTION: Resolution 007 adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy.

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

Online testimony was mixed. At the in-person hearing, the author proffered an amendment. Testimony was in unanimous support of adoption as amended. Your Reference Committee recommends that the resolution be adopted as amended.

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(22) RESOLUTION 010 - FATIGUE MITIGATION: SUPPORTING FULLY-FUNDED TRANSPORTATION FOR TRAINEE PHYSICIANS AFTER EXTENDED OR OVERNIGHT SHIFTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 010 be amended by addition and deletion as follows:

> RESOLVED, that our American Medical Association supports the requirement for sponsoring institutions to fully fund ~~provision of fully-funded~~ transportation options (including, but not limited to, rideshares and taxis) for ~~intern, resident, and fellow physicians~~ trainees after extended or overnight shifts as a core fatigue mitigation strategy, with costs not borne by trainees.

RECOMMENDATION B:

That Resolution 010 be adopted as amended.

HOD ACTION: Alternate Resolution 010 adopted in lieu of Resolution 010.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association supports sponsoring institutions providing access to financially-supported transportation assistance and other appropriate fatigue-mitigation resources for trainee physicians following extended duty periods when fatigue may impair safe travel, with consideration given to local resource availability, geographic constraints, and institutional capacity.

RESOLVED, that our American Medical Association supports the provision of fully-funded transportation options (including, but not limited to, rideshares and taxis) for intern, resident, and fellow physicians after extended or overnight shifts as a core fatigue mitigation strategy, with costs not borne by trainees. (New HOD Policy)

Online testimony was in strong support. An amendment was proffered to clarify who should be responsible for the financial burden. A second amendment was proffered to replace “intern, resident, and fellow physicians” with “trainee” to better reflect the title of the resolution and use more inclusive language. In-person testimony was mixed between support of the resolution and referral, with a slight majority in favor of adoption as amended by the Reference Committee. Testimony in support of referral referenced unintended consequences including prohibitive cost, potential risk, and liability. Testimony in support of the Reference Committee’s recommendation voiced the

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importance of addressing fatigue mitigation, safety concerns, and liability. Your Reference Committee recommends that the resolution be adopted as amended.

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RECOMMENDED FOR REFERRAL

(23) CEJA REPORT 01 - GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 01 be referred.

HOD ACTION: CEJA Report 01 referred.

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

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

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

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

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

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

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

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i) If the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician.
ii) In emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale.

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

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

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

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

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

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

For non-sensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request.
(Modify HOD/CEJA Policy)

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

Online testimony was mixed, split between support and referral. In-person testimony was mixed with a majority in favor of referral. Calls for referral noted that the recommendations are overly prescriptive and difficult to implement. Your Reference Committee recommends that the report be referred.

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(24) CEJA REPORT 03 - SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE ACTIONS AND/OR UNIONIZATION

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 03 be referred.

HOD ACTION: CEJA Report 03 referred.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Online testimony was mixed, with a slight majority in favor of referral. In-person testimony was strongly in favor of referral, noting that some of the language was too broad and needed greater clarification. Your Reference Committee recommends that the report be referred.

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RECOMMENDED FOR NOT ADOPTION

(25) RESOLUTION 006 - INVESTIGATING MORAL INJURY RELATED TO ORGAN PROCUREMENT PRACTICES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 006 be not adopted.

HOD ACTION: Resolution 006 not adopted.

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

Online testimony was mixed, with a majority opposed. In-person testimony was mixed, with a majority opposed. Testimony in favor of adoption noted concerns for present moral distress that warrant urgency in addressing the matter. Testimony in opposition noted that OPTN and HRSA are actively reviewing this issue, and that it is essential to hold off on any decisions until there is a clear understanding of the new processes and polices that are in development. Your Reference Committee recommends that the resolution be not adopted.

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(26) RESOLUTION 012 - TAKING ACTION ON DEATHS IN CUSTODY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 012 be not adopted.

HOD ACTION: Resolution 012 referred.

RESOLVED, that our American Medical Association endorse and support the recommendations of the National Academies of Science Committee on Advancing the Field of Forensic Pathology: Lessons Learned from Death-in-Custody Investigations Consensus Report to strengthen the U.S. medicolegal death investigation system. (New HOD Policy)

In-person testimony was mixed. Those in opposition supported the intent of the resolution but would prefer to have AMA policy not be tied to policy from an external organization. Testimony in favor of referral suggested report back at I-26. Testimony in support noted that action is needed on this issue. All testimony was in general support for the spirit of the resolution, but concern was raised that American College of Correctional Physicians and American Academy of Psychiatry were not included in the drafting of the policy or this resolution. Your reference committee recommends that the resolution be not adopted.

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RECOMMENDED FOR FILING

(27) BOT REPORT 36 - UPDATE ON THE REPORT OF THE TRHT TASK FORCE TO THE AMA BOARD OF TRUSTEES

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 36 be filed.

HOD ACTION: Addition of a recommendation adopted and the remainder of the report filed.

ADOPTED LANGUAGE:

That our American Medical Association establish a multi-session educational series for the House of Delegates, commencing at I-26, focused on the work of the Truth, Reconciliation, Healing, and Transformation (TRHT) Task Force, including:

1. **Opportunities for members to directly engage in programming regarding the Task Force's process, historical findings, framework, and lessons learned;**
2. **Sessions organized around major areas of historical examination undertaken by the Task Force; and**
3. **An open forum as part of this educational series to provide members an opportunity to participate in dialogue regarding truth, reconciliation, healing, and transformation, strengthen organizational capacity, and identify opportunities to advance TRHT principles to the extent allowed by fiduciary, legal, and financial review.**

In-person testimony was in near universal support of adoption with a proffered amendment to add a resolve clause to the informational report. During testimony, the Board acknowledged their shortcomings, including a lack of transparency, and committed to additional action. In consultation with the Office of General Counsel, it was determined that the proffered amendment as written would waive attorney-client privilege. Accordingly, your Reference Committee rejected the proffered amendment and recommends that the report be filed.

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Madam Speaker, this concludes the report of Reference Committee on Ethics and Bylaws. I would like to thank Dr. Elziabeth Ignacio, Dr. Hemant Kalia, Dr. Vivek Rao, Dr. Ryan Singerman, Dr. Donald Swikert, and Dr. Valencia Walker and all those who testified before the committee.

Elizabeth Ignacio, MD
Hawaii Delegation

Hemant Kalia, MD, MPH
New York Delegation

Vivek Rao, MD
Texas Delegation

Ryan Singerman, DO
Indiana Delegation

Donald Swikert, MD
Kentucky Delegation

Valencia Walker, MD, MPH
California Delegation

Carlos Latorre, MD
Mississippi Delegation
Chair

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DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee F

Robert A. Gilchick, MD, MPH, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 - AMA 2027 Dues
2. Board of Trustees Report 34 - Discontinuation of AMA Citation for Distinguished Service
3. Board of Trustees Report 38 - Project IMG Observer Status in the House of Delegates
4. Report of the House of Delegates Committee on the Compensation of the Officers
5. Resolution 607 - Shortening the AMA House of Delegates Endorsement Process and Timeline
6. Resolution 619 - Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals
7. Resolution 620 - Survey of Medical Staffs

RECOMMENDED FOR ADOPTION AS AMENDED

8. Resolution 602 - Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones
9. Resolution 603 - Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy
10. Resolution 610 - Plant-Based Diets at AMA Meetings
11. Resolution 612 - Increasing Expert Guidance in AMA Statements
12. Resolution 615 - Condemnation of Attacks on Healthcare Workers and Facilities in Gaza

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Resolution 601 - Board Chair Term Limits
    Resolution 609 - American Medical Association Board Chair Term Limits
14. Resolution 608 - Reinstitution of AMA Guides Editorial Panel

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RECOMMENDED FOR REFERRAL

15. Resolution 604 - Annual Scorecard to Evaluate the AMA's Impact
16. Resolution 605 - Review of Past Resolutions
17. Resolution 611 - Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices
18. Resolution 613 - Preserving Institutional Equity and Inclusivity Efforts
19. Resolution 616 - Humanitarian and Medical Aid Support to Palestine

RECOMMENDED FOR REFERRAL FOR DECISION

20. Resolution 618 - Ending AMA Investment in Weapons Manufacturers

RECOMMENDED FOR NOT ADOPTION

21. Resolution 606 - Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
22. Resolution 614 - Inclusive Policy Language for Older Adults
23. Resolution 617 - Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association

RECOMMENDED FOR FILING

24. Board of Trustees Report 1 - Annual Report
25. Council on Long Range Planning and Development Report 01 – Update on CLRPD Evaluation of the Structure of the House of Delegates

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RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2027 DUES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION:
Board of Trustees Report 4 adopted and remainder of report filed.

The Board of Trustees recommends no change to the dues levels for 2027, that the following be adopted and that the remainder of this report be filed:

Regular Members	$420
Physicians in Their Fourth Year of Practice	$315
Physicians in Their Third year of Practice	$210
Physicians in Their Second Year of Practice	$105
Physicians in Their First Year of Practice	$60
Physicians in Military Service	$280
Semi-Retired Physicians	$210
Fully Retired Physicians	$84
Physicians in Residency/Fellow Training	$45
Medical Students	$20

(Directive to Take Action)

Testimony in response to Board of Trustees Report 4 was strongly supportive of maintaining the current AMA dues structure for 2027.

Your Reference Committee recommends that Board of Trustees Report 4 be adopted.

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(2) BOARD OF TRUSTEES REPORT 34 - DISCONTINUATION OF AMA CITATION FOR DISTINGUISHED SERVICE

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 34 be adopted and the remainder of the Report be filed.

HOD ACTION:
Board of Trustees Report 34 adopted and remainder of report filed.

The Board of Trustees recommends that the following be adopted and the remainder of the report filed.

That the AMA Bylaws be amended to eliminate reference to the Citation for Distinguished Service.

(Modify Bylaws)

Testimony in response to Board of Trustees Report 34 was limited, yet supportive of the recommendation to eliminate the reference to the Citation for Distinguished Service.

Your Reference Committee recommends Board of Trustees Report 34 be adopted.

(3) BOARD OF TRUSTEES REPORT 38 - PROJECT IMG OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 38 be adopted and the remainder of the Report be filed.

HOD ACTION:
Board of Trustees Report 38 adopted and remainder of report filed.

The Board of Trustees recommends that Project IMG be admitted as an Official Observer in the House of Delegates, and the remainder of this report be filed.

Testimony in response to Board of Trustees Report 38 was limited but supportive. Therefore, your Reference Committee recommends adoption.

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(4) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION:
Report of the House of Delegates Committee on the Compensation of the Officers adopted and remainder of report filed.

The Committee on Compensation of the Officers recommends the following changes to Officer compensation be adopted effective July 1, 2026, and the remainder of this report be filed:

1. That the maximum annual secretarial reimbursement for the Speaker and Vice Speaker is increased from $2,500 to $5,000 to reflect the increasing secretarial needs of these positions.

2. That the maximum annual secretarial reimbursement for non-leadership Officers is increased from $1,125 to $1,200 to reflect a modest cost-of-living adjustment.

3. That the travel upgrade allowance for the Presidents (President, Immediate Past President and President Elect) is increased from $5,000 to $6,000.

4. That the Board Chair is moved to the same travel upgrade allowance as Presidents.

5. That the travel upgrade allowance for all other Officers is increased from $2,500 to $3,000.
6. That the definition of the Secretarial Expenses be revised as follows:

   The AMA will provide a stipend of $15,000 to provide secretarial support at a designated location, other than the AMA, for the President during the Presidential year. Secretarial expenses are paid for the President-Elect, Chair, Chair-Elect, ~~and~~ Immediate Past President, Speaker and Vice Speaker to a maximum of $5,000 per officer. If the officer holds office for only one-half of the calendar year (January-June or June-December), expense reimbursement will be a maximum of $2,500 per officer. Secretarial expenses incurred by other officers in connection with their official duties are paid up to ~~$1125~~ $1,200 per year per general officer.

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7. That the definition of Transportation be revised as follows:

Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) and Chair will each have access to an individual ~~$5,000~~ $6,000 term allowance (July 1 to June 30) and all other Officers will each have access to ~~$2,500~~ an individual $3,000 term allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA.

In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized, when necessary, by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV—Invitations, B–Foreign, for policy on foreign travel).

8. That the remainder of the report be filed.

Testimony in response to the Report of the House of Delegates Committee on the Compensation of the Officers supported the recommended increases to secretarial reimbursements and travel upgrade allowances, as well as revisions to the definitions of secretarial expenses and transportation to better reflect current needs and cost-of-living adjustments. The recommendations were seen as reasonable updates to ensure appropriate support and recognition for AMA Officers considering evolving responsibilities and financial circumstances.

Your Reference Committee recommends that the Report of the House of Delegates Committee on the Compensation of the Officers be adopted.

(5) RESOLUTION 607 - SHORTENING THE AMA HOUSE OF DELEGATES ENDORSEMENT PROCESS AND TIMELINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 607 be adopted.

HOD ACTION:
Resolution 607 adopted.

RESOLVED, that our American Medical Association amend Policy G-610.090, "AMA Election Rules and Guiding Principles," by addition and deletion, effective immediate to the 2028 election endorsement cycle, to read as follows:

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G-610.090 AMA Election Rules and Guiding Principles

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner, no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.

3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.

4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought, with the endorsement window opening at the commencement of the Interim Meeting immediately preceding the Annual Meeting at which the election is to take place.

In response to Resolution 607, testimony referencing the work of the Election Task Force indicated that closing the endorsement window before the Annual Meeting candidate announcement deadline helps prevent election rule violations and limits campaigning during meetings, allowing more time for policy discussions. The Task Force determined that interviews, rather than endorsements, are most important to voters, advocating for the separation of endorsements from the interview process to promote fairness.

Testimony was supportive of the resolution and indicated that a shortened timeline would enhance the current process for candidate endorsements and minimize the potential for changes in plans for candidates or endorsing groups. Consequently, your Reference Committee recommends adopting Resolution 607.

(6) RESOLUTION 619 – OPPOSING FEDERAL IMMIGRATION OPERATIONS AT AMA EVENTS AND HARM TO LAWFUL NON-TARGET INDIVIDUALS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause in Resolution 619 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause in Resolution 619 be referred for a report back at I-26.

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RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause in Resolution 619 be referred for a report back at I-26.

HOD ACTION:
Resolution 619 adopted as amended.

RESOLVED, that our American Medical Association opposes federal immigration operations without a judicial warrant at AMA events; and be it further

RESOLVED, that our AMA supports federal, state, and institutional policies that prevent immigration enforcement actions from interfering with the ability of physicians, trainees, and other health care professionals to attend conferences, complete training, or provide patient care, except where required by a valid judicial order; and be it further

RESOLVED, that our AMA supports the use of visible identification by federal immigration enforcement personnel at physician conferences, in medical training sites, or in patient care settings.

RESOLVED, that our American Medical Association opposes federal immigration operations without a judicial warrant at AMA events; and be it further

RESOLVED, that our AMA supports federal, state, and institutional policies that prevent immigration enforcement actions from interfering with the ability of physicians, trainees, and other health care professionals to attend conferences, complete training, or provide patient care, except where required by a valid judicial order; and be it further

RESOLVED, that our AMA supports the use of visible identification by federal immigration enforcement personnel as a measure to uphold ethical standards, public trust, transparency, and accountability in cases where their actions may result in health-related harms.

Mixed testimony supported the intent of the resolution to protect physicians and patients. It was noted that AMA policy centers on protections for patients without addressing similar safeguards for physicians and trainees. Although concern was expressed over potential unintended consequences of the first Resolve, your Reference Committee believes that extending protections related to immigration enforcement for physicians and trainees, specifically AMA event attendees, is essential.

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Additional testimony expressed that the third Resolve may not be suitable for implementation by the AMA. Your Reference Committee concurs and believes the second Resolve may also present similar concerns related to the broad scope of travel and wide breath of events referenced.

Your Reference Committee proposes adoption of the first Resolve and referral of the second and third Resolves to allow for further study with a report back at the 2026 Interim Meeting.

(7) RESOLUTION 620 - SURVEY OF MEDICAL STAFFS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 620 be adopted.

HOD ACTION:
Resolution 620 adopted.

RESOLVED, that our American Medical Association work with the Organized Medical Staff Section to sponsor a survey of sufficient statistical power to determine the spectrum of composition and influence of the contemporary medical staff across the United States, including but not limited to information such as:

- Is your hospital owned by a system, is it independent, or is it affiliated with a system?
- Do you have your own medical staff with officers? If part of a system, is there one medical staff for the system or does each facility have its own?
- What are the categories of medical staff membership? Please define these.
- Are the officers appointed by the hospital or are they elected by the medical staff?
- Is there a medical staff executive committee (MEC) that meets regularly? How often? Does it meet with hospital leadership? Do non-medical staff members have a vote on the MEC?
- To what degree are independent physicians (solo, members of group organizations, etc) versus employed physicians active in the administration of medical staff, i.e. involvement in committees or ad hoc initiatives?

Testimony in response to Resolution 620 was supportive, yet limited, regarding the recommendation for our AMA to work with the Organized Medical Staff Section on a survey to learn more about contemporary medical staff across the United States.

Your Reference Committee looks forward to learning more about the survey design, including intended respondents.

Therefore, your Reference Committee recommends adoption of Resolution 620.

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RECOMMENDED FOR ADOPTION AS AMENDED

(8) RESOLUTION 602 - PROTECTION OF HEALTHCARE AND HUMANITARIAN AID PERSONNEL IN CONFLICT ZONES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 602 be amended by addition and deletion to read:

RESOLVED, that our American Medical Association will amend H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict by addition and deletion to read as follows:

a. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.

b. Our American Medical Association supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

~~c. Our American Medical Association condemns the use of all forms of violence, forced displacement, and obstruction of any aid and healthcare in any location against healthcare personnel, humanitarian aid workers, and healthcare institutions.~~

~~d~~c. Our American Medical Association condemns ~~advocates for an absolute ban on~~ targeting, detention, or attack of non-combatant healthcare workers and humanitarian personnel~~;, and their institutions,~~ and our AMA also ~~simultaneously~~ condemns the use of healthcare workers, humanitarian personnel, and healthcare institutions for military purposes or as shields for military operations ~~demands the immediate release of any healthcare or humanitarian personnel held captive~~.

~~e. Our American Medical Association actively opposes the use of force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, whether domestically or internationally.~~

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RECOMMENDATION B:

Your Reference Committee recommends that Resolution 602 be adopted as amended.

HOD ACTION:
Resolution 602 adopted as amended.

RESOLVED, that our American Medical Association will amend Policy H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict to read as follows:

a. Our American Medical Association supports peace in the world in order to protect civilian lives and healthcare personnel.

b. Our American Medical Association supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

c. Our American Medical Association condemns targeting, detention, or attack of non-combatant healthcare workers and humanitarian personnel; and our AMA also condemns the use of healthcare workers, humanitarian personnel, and healthcare institutions for military purposes or as shields for military operations.

RESOLVED, that our American Medical Association will amend H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict by addition to read as follows:

a. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.

b. Our American Medical Association supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

c. Our American Medical Association condemns the use of all forms of violence, forced displacement, and obstruction of any aid and healthcare in any location against healthcare personnel, humanitarian aid workers, and healthcare institutions.

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d. Our American Medical Association advocates for an absolute ban on targeting, detention, or attack of healthcare workers, humanitarian personnel, and their institutions, and demands the immediate release of any healthcare or humanitarian personnel held captive.

e. Our American Medical Association actively opposes the use of force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, whether domestically or internationally.

Testimony in response to Resolution 602 was sharply divided.

Those who support Resolution 602 argue the resolution upholds ethical and humanitarian principles by protecting healthcare and aid workers in conflict zones globally and domestically, emphasizing rising violence against healthcare professionals and aligning with international humanitarian law and medical ethics. They assert that the resolution is not singularly focused on one conflict or region, but rather addresses the widespread dangers faced by noncombatant healthcare workers and humanitarian personnel everywhere, advocating for their safety, medical neutrality, and unfettered access to essential care. The supporting position stresses that it is within the purview of medical organizations to speak out against violence directed at healthcare workers and to uphold the core values of the profession.

Opponents of Resolution 602 indicated that the resolution is redundant, as existing AMA policies and international law already cover the protection of healthcare workers and medical neutrality. Many raised concerns that the proposed amendments primarily target one conflict, unnecessarily focusing on Israel and Palestine, leading to perceptions of bias and politicization. Critics highlight that healthcare personnel and facilities can be misused for military purposes in modern conflicts, citing documented instances of hospitals and ambulances being exploited by combatants, which complicates blanket prohibitions and undermines protected status. They caution that the resolution's call for an absolute ban on targeting, detention, or attack is inconsistent with established international humanitarian law, which removes protections if medical facilities are used for hostile acts. Furthermore, opponents question the scope and relevance of the AMA's involvement in international disputes, advocating instead for a focus on core missions such as advancing patient care and physician welfare within the United States.

Your Reference Committee agrees with the testimony indicating that components of Resolution 602 are redundant with current Policy H-520.985 (items a and b). Additionally, your Reference Committee favors the positive language of original policy. However; your Reference Committee believes additional language proffered in item d adds substantially to existing policy and reflects the testimony provided regarding the potential adverse consequences to healthcare workers in areas of armed conflict. Therefore, your Reference Committee recommends that Resolution 602 be adopted as amended.

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(9) RESOLUTION 603 - ESTABLISH AMA POLICY AND PROJECT TO COMPILE AND DISTRIBUTE JAMA PATIENT PAGES TO ENHANCE PUBLIC MEDICAL LITERACY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 603 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association publicize ~~publized~~ the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 603 be deleted.

~~RESOLVED, that our AMA shall compile and organize previously published JAMA Patient Pages into a publicly accessible database or repository for the purpose of improving medical literacy and fostering patient-physician partnerships (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 603 be amended by addition and deletion as follows:

RESOLVED, that our AMA explore ~~explores~~ opportunities to promote awareness, ~~and~~ utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 603 be adopted as amended.

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HOD ACTION:
Resolution 603 adopted as amended.

> **RESOLVED, that our American Medical Association publicize the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (Directive to Take Action); and be it further**
>
> **RESOLVED, that our AMA explore opportunities to promote awareness, ~~and~~ utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)**

RESOLVED, that our American Medical Association publized the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (Directive to Take Action); and be it further

RESOLVED, that our AMA shall compile and organize previously published JAMA Patient Pages into a publicly accessible database or repository for the purpose of improving medical literacy and fostering patient-physician partnerships (Directive to Take Action); and be it further

RESOLVED, that our AMA explores opportunities to promote awareness and utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)

Testimony in response to Resolution 603 was mostly favorable. One supportive comment expressed concern that the cost of implementing the second Resolve may have been underestimated.

Your Reference Committee notes that the Patient Pages, which are searchable by topic and specialty, are accessible through the JAMA Patient Information webpage at https://jamanetwork.com/collections/6258/patient-information. Accordingly, your Reference Committee recommends deleting the second Resolve as it has been accomplished by this online resource. Further, the third Resolve reflects options for optimizing access to the JAMA Patient Pages, which supports concerns related to ease of use.

Further, editorial changes are recommended by your Reference Committee for the first and third Resolves.

Your Reference Committee recommends that Resolution 603 be adopted as amended.

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(10) RESOLUTION 610 - PLANT-BASED DIETS AT AMA MEETINGS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 610 be amended by deletion as follows:

RESOLVED, that our American Medical Association encourages the use of evidence-based behavioral science strategies~~, such as choice architecture and nudging,~~ to promote healthier dietary choices at professional gatherings, while respecting individual autonomy (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 610 be amended by addition as follows:

RESOLVED, that our American Medical Association recognizes the importance of modeling prevention through food choices at its own meetings whenever possible, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 610 be adopted as amended.

HOD ACTION:
Resolution 610 adopted as amended.

RESOLVED, that our American Medical Association encourages the use of evidence-based behavioral science strategies to promote healthier dietary choices at professional gatherings, while respecting individual autonomy (New HOD Policy); and be it further

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RESOLVED, that our American Medical Association recognizes the importance of modeling prevention through food choices at its own meetings whenever possible, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health. (New HOD Policy)

RESOLVED, that our American Medical Association encourages the use of evidence-based behavioral science strategies, such as choice architecture and nudging, to promote healthier dietary choices at professional gatherings, while respecting individual autonomy (New HOD Policy); and be it further

RESOLVED, that our American Medical Association recognizes the importance of modeling prevention through food choices at its own meetings, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health. (New HOD Policy)

Testimony in response to Resolution 610 was largely supportive, highlighting the personal and environmental health benefits of plant-based diets, behavioral modeling for patients and better experience for meeting attendees who prefer plant-based options.

However, concerns were raised regarding certain nuances relating to nutrition science and environmental sustainability as well as the ability to retain individual choice.

Your Reference Committee acknowledges the concerns raised in testimony about the use of “choice architecture and nudging” in the first Resolve, and possible implications for personal choice. Further, your Reference Committee notes that factors such as meeting venue may influence the availability of plant-based meal options and recommends that the second Resolve be amended accordingly.

Your Reference Committee recommends that Resolution 610 be adopted as amended.

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(11) RESOLUTION 612 - INCREASING EXPERT GUIDANCE IN AMA STATEMENTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 612 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association consult with ~~multidisciplinary AMA section-identified~~ multiple experts representing various disciplines when crafting specialist care focused statements, especially statements predominantly discussing care for vulnerable populations, to reduce the risk of harm to said populations. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 612 be adopted as amended.

HOD ACTION:
Resolution 612 adopted as amended.

RESOLVED, that our American Medical Association consult with multiple experts representing various disciplines when crafting specialist care focused statements, especially statements predominantly discussing care for vulnerable populations, to reduce the risk of harm to said populations. (Directive to Take Action)

RESOLVED, that our American Medical Association consult with multidisciplinary AMA section-identified experts when crafting specialist care focused statements, especially statements predominantly discussing care for vulnerable populations, to reduce the risk of harm to said populations. (Directive to Take Action)

The majority of testimony in response to Resolution 612 was in support of requiring broader expert consultation when the AMA crafts statements relating to specialist care, especially concerning vulnerable populations. Supporters emphasized the crucial role of multidisciplinary expertise to ensure accuracy, policy alignment, and the protection of patient welfare, citing past instances where insufficient consultation led to confusion, harm, and reputational damage for the AMA. Advocates underscored the need for input from a range of clinical specialists as well as leaders representing marginalized groups, arguing this approach would mitigate risks of miscommunication, ensure nuanced guidance, and maintain trust both internally and externally.

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Concerns were raised regarding the feasibility and governance implications of mandating formal consultation with AMA Section-identified experts, noting that rapid response may be hindered by such requirements and that AMA Sections are not intended to function as formal advisory bodies.

Your Reference Committee recommends amending the resolution by addition and deletion to reflect that expert consultations should not be limited to AMA Sections but should include relevant input from across the entire spectrum of clinical expertise.

(12) RESOLUTION 615 - CONDEMNATION OF ATTACKS ON HEALTHCARE WORKERS AND FACILITIES IN GAZA

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 615 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association recognize the deliberate targeting of non-combatant healthcare workers, medical students, and healthcare facilities in all areas of conflict ~~Gaza~~ as a violation of medical neutrality and AMA policy (New AMA Policy).~~; and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 615 be deleted.

~~RESOLVED, that our AMA supports efforts to protect, release, and provide restitution to detained healthcare workers in Gaza. (New HOD Policy)~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 615 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 615 be changed as follows:

PROTECTION OF NON-COMBATANT HEALTHCARE WORKERS AND FACILITIES IN CONFLICT AREAS

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HOD ACTION:
Resolution 615 adopted as amended.

> **PROTECTION OF NON-COMBATANT HEALTHCARE WORKERS AND FACILITIES IN CONFLICT AREAS**
>
> **RESOLVED, that our American Medical Association recognize the deliberate targeting of non-combatant healthcare workers, medical students, and healthcare facilities in all areas of conflict as a violation of medical neutrality and AMA policy (New AMA Policy).**
>
> **RESOLVED, that our AMA supports efforts to protect, release, and provide restitution to detained non-combatant healthcare workers in all areas of conflict.**

RESOLVED, that our American Medical Association recognize the deliberate targeting of healthcare workers, medical students, and healthcare facilities in Gaza as a violation of medical neutrality and AMA policy (New AMA Policy); and be it further

RESOLVED, that our AMA supports efforts to protect, release, and provide restitution to detained healthcare workers in Gaza. (New HOD Policy)

Testimony in response to Resolution 615 was mixed, citing concerns about political bias, singling out Gaza, and misalignment with our AMA's mission. Many argued the resolution overlooked similar issues elsewhere and highlighted the complexity of military use of healthcare facilities in Gaza. Support focused on medical neutrality and universal protection for healthcare workers.

Your Reference Committee believes the proffered amendment addresses key concerns by extending condemnation to the deliberate targeting of non-combatant healthcare workers and facilities in all conflict areas, as well as removing the clause on Gaza-specific efforts. Your Reference Committee favors adoption of Resolution 615 as amended because the revision aligns the resolution with AMA policy and emphasizes a global, ethical commitment to protection for healthcare workers and other non-combatants from adversity derived from active combat. Lastly, your Reference Committee recommends the title be changed to align with the amended language.

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RECOMMENDED FOR ADOPTION IN LIEU OF

(13) RESOLUTION 601 - BOARD CHAIR TERM LIMITS
RESOLUTION 609 - AMERICAN MEDICAL ASSOCIATION BOARD CHAIR TERM LIMITS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 601 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association utilize ~~commission~~ an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations (Directive to Take Action; and be it further

RESOLVED, that our AMA examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and AMA membership (Directive to Take Action); and be it further

RESOLVED, that our AMA provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the AMA (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the AMA Constitution and Bylaws for consideration by the House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 601 as amended be adopted in lieu of Resolution 609.

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HOD ACTION:
Resolution 601 adopted in lieu of Resolution 609.

RESOLUTION 601

RESOLVED, that our American Medical Association commission an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and AMA membership (Directive to Take Action); and be it further

RESOLVED, that our AMA provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the AMA (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the AMA Constitution and Bylaws for consideration by the House of Delegates. (Directive to Take Action)

RESOLUTION 609

RESOLVED, that our American Medical Association Board of Trustees commission an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations (Directive to Take Action); and be it further

RESOLVED, that this independent assessment examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and American Medical Association membership (Directive to Take Action); and be it further

RESOLVED, that the Board of Trustees provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the American Medical Association (Directive to Take Action); and be it further

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RESOLVED, that the Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the American Medical Association Constitution and Bylaws for consideration by the House of Delegates. (Directive to Take Action)

Testimony received in response to Resolution 601 was mostly supportive, noting the potential of an independent consult to strengthen AMA Board governance, succession planning and leadership continuity.

Opposing testimony, while supportive of the resolution's intent, indicated that two independent consulting firms have been engaged to assess Board operations and interactions with AMA management.

Further, it was noted that significant overlap exists with Resolution 609, which also calls for an assessment of the AMA Board structure, succession planning and leadership continuity.

Your Reference Committee concurs and recommends that Resolution 601 be adopted as amended in lieu of Resolution 609.

(14) RESOLUTION 608 - REINSTITUTION OF AMA GUIDES EDITORIAL PANEL

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 608 be adopted in lieu of Resolution 608.

UPDATING THE *AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT*

RESOLVED, that our American Medical Association Board of Trustees develop, with input from physician stakeholders, relevant specialty societies, and users of the *AMA Guides to the Evaluation of Permanent Impairment*, a plan for ongoing updates, clinical oversight, transparency, governance, and sustainable funding of the AMA Guides to the Evaluation of Permanent Impairment with a goal of creating the most effective model to encourage the uptake of up-to-date information when evaluating impaired patients, and report back on that plan at the 2027 Annual Meeting; and be it further

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RESOLVED, that our AMA continue the work of timely chapter updates for the *AMA Guides to the Evaluation of Permanent Impairment,* Sixth Edition 2025 that have not yet been addressed, in order to ensure that new evidence or diagnostic criteria is incorporated into chapter updates, ensuring the utilization of specialty-specific physician input in the evaluation of permanent impairment; and be it further

RESOLVED, that Policy H-365.987, which states that "It is the policy of the AMA: (1) to pursue the comprehensive revision and updating of the Guides to the Evaluation of Permanent Impairment with input from physicians in all appropriate specialty groups; and (2) to consider developing appropriate methods to facilitate the use of the Guides, including expansion of introductory instructions," be reaffirmed.

HOD ACTION:
Alternate Resolution 608 adopted in lieu of Resolution 608.

RESOLVED, that our American Medical Association re-institute the AMA Guides Editorial Panel to its original configuration and operating status (Directive to Take Action; and be it further

RESOLVED, that our AMA encourage the AMA Guides Editorial Panel to continue its work on updating the chapters of the AMA Guides to the Evaluation of Permanent Impairment 6th edition 2025 that have yet to be addressed and to continue to bring current evidence based medicine and practices to the evaluation of permanent impairment. (Directive to Take Action)

Testimony in response to Resolution 608 overwhelmingly favored maintaining and updating the *AMA Guides to the Evaluation of Permanent Impairment*.

With respect to the editorial panel, the Board of Trustees noted that AMA staff carefully reviewed market feedback, content development, and financial considerations before retiring the editorial panel. According to the Board testimony, the panel was established in 2019 to update the AMA Guides, but it became clear that its ongoing, chapter-by-chapter update model did not align with the preferences of key stakeholders, mainly state workers' compensation regulators. These regulators prefer comprehensive, finalized updates due to the lengthy and complex process required for state adoption, making iterative updates impractical and limiting the adoption of new content.

Supporters emphasized the importance of a continuously updated, evidence-based reference for impairment evaluation, highlighting that partial updates which leave certain chapters outdated are unfair to patients and problematic for physicians. Several comments noted that discontinuation of the panel occurred without a clear or formalized plan for future updates and questioned the validity of relying primarily on state regulators.

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Concerns were raised over reverting to a model based on ad hoc committees, which historically lacked transparency and broad stakeholder input. The consensus among supporters was that maintaining a standing editorial panel ensures scientific consistency, integrity, and practical usability, and provides reliable methods for impairment rating across specialties.

Testimony supported an alternate resolution to address concerns related to the AMA's plan for ongoing updates and oversight of the AMA Guides in light of the gap that has been created by the discontinuation of the editorial panel. Your Reference Committee proffered amendments to further enhance the proposed language.

Therefore, your Reference Committee recommends that Alternate Resolution 608 be adopted.

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RECOMMENDED FOR REFERRAL

(15) RESOLUTION 604 - ANNUAL SCORECARD TO EVALUATE THE AMA'S IMPACT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 604 be referred.

HOD ACTION:
Resolution 604 adopted as amended.

RESOLVED, that our American Medical Association shall implement a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics:

1. **Medicare Impact: percent change in the Medicare Physician Fee Schedule;**
2. **Advocacy Impact: number of federal policies successfully influenced or implemented;**
3. **House of Delegates Impact: number of AMA policies translated into legislation or federal policy;**
4. **Financial Impact: percentage of revenue dedicated to advocacy; and,**
5. **Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers (Directive to Take Action); and be it further**

RESOLVED, that our AMA shall review metric definitions and targets and provide a report by the 2027 AMA Annual Meeting. Any future updates to metrics or targets shall be recommended via a report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect (Directive to Take Action); and be it further

RESOLVED, that our AMA shall publish the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2028. (Directive to Take Action)

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RESOLVED, that our American Medical Association consider implementing a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics:

1. Medicare Impact: percent change in the Medicare Physician Fee Schedule;
2. Advocacy Impact: number of federal policies successfully influenced or implemented;
3. House of Delegates Impact: number of AMA policies translated into legislation or federal policy;
4. Financial Impact: percentage of revenue dedicated to advocacy; and,
5. Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers (Directive to Take Action); and be it further

RESOLVED, that our AMA shall review metric definitions and targets and provide a report by the 2027 AMA Annual Meeting. Any future updates to metrics or targets shall be recommended via a report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect (Directive to Take Action); and be it further

RESOLVED, that our AMA shall consider publishing the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2028. (Directive to Take Action)

Testimony in response to Resolution 604 reflected a spectrum of opinions with a significant portion supporting the concept of developing an AMA performance scorecard, while notable concerns were raised, including opposition from the Board of Trustees.

Supporters of the resolution emphasized the value of transparency, accountability, and the alignment of AMA activities with measurable outcomes tied to organizational priorities. They indicated that such a scorecard would provide members and non-members alike with a clearer understanding of the AMA's effectiveness in advocacy, engagement, and policy advancement, and argue that the proposed mechanism aligns with standard practices in other major organizations.

Concerns centered on the potential for oversimplification, metric fixation, and the risk that reporting on certain measures could lead to misinterpretation or unintended incentives. There were additional arguments about the importance of maintaining appropriate distinctions between governance and operational management, and cautioned about inadvertently undermining member confidence through poorly designed metrics. Attention was drawn to whether such performance measures should be subject to approval by the House of Delegates and the risk of requiring reporting that could breach confidentiality or legal responsibilities. Many commenters advocated for referral of the resolution to ensure that any future metrics are carefully developed, validated, and contextualized, thereby addressing concerns about feasibility, unintended consequences, and alignment with AMA's governance structure and long-term mission.

Your Reference Committee recommends that Resolution 604 be referred for report back on the concerns that were raised.

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(16) RESOLUTION 605 - REVIEW OF PAST RESOLUTIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 605 be referred.

HOD ACTION:
Resolution 605 referred with report back at A-27.

RESOLVED, that our American Medical Association consider presenting, by the 2027 AMA Annual Meeting, a detailed and aggregate report that is easily accessible and includes the following data for the past 10 years; the total number of resolutions submitted and passed; the number of those resolutions specific to advocacy on the sustainability of medical practices; a breakdown of these resolutions by Annual and Interim meetings; and the percentage of resolutions that have been successfully implemented. The report shall be produced on an annual basis and included in the Annual meeting handbook. (Directive to Take Action)

While testimony was generally supportive of the intent of Resolution 605, various amendments were proffered regarding options for completing the review of past resolutions.

Opposing testimony expressed support for the goals conveyed in the resolution and further noted that a multiyear effort is underway to improve the AMA's policymaking infrastructure. Testimony indicated that it would be difficult to implement the resolution prior to completing this work.

Given the disparate nature of the proposed amendments and ongoing efforts to enhance the policy infrastructure, your Reference Committee believes that a study is merited to determine the best path forward.

Therefore, your Reference Committee recommends that Resolution 605 be referred.

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(17) RESOLUTION 611 - PUBLICIZING, SUPPORTING, AND PROMOTING (APPROPRIATE) AMA MEMBER PHYSICIANS AND PHYSICIAN SPOUSES AS CANDIDATES FOR LOCAL AND STATE OFFICES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 611 be referred.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 611 be referred.

HOD ACTION:
First and Second Resolves in Resolution 611 referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 611 be amended by addition of a third Resolve clause:

RESOLVED, that the AMA will present for information via the AMA website an annual Physician+Alliance Election Report detailing the outcomes for physician and physician spouse candidates, beginning with the 2026 General Election in November, to include a scorecard identifying all such candidates who ran at the state or national level to include office sought, election district, party affiliation, any medical PAC endorsements, final election results with margins (+/-) and other pertinent details.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 611 be adopted as amended.

HOD ACTION:
Resolution 611 adopted as amended.

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RESOLVED, that our American Medical Association, to the extent permitted by applicable laws, collaborate with other interested organizations to facilitate opportunities for AMA physician-member and physician-spouse elected officials at the local and state levels to connect, exchange ideas, collaborate, and support each other to protect our patients and our practices, such as with a "National Meeting of Physician State Legislators" (Directive to Take Action); and be it further

RESOLVED, that our AMA study the:

1. Feasibility of collaborating with state medical societies and specialty societies to assess appropriate AMA physician members and physician spouses running for state and local offices and creating a "master list" to publicize, support, and promote those individuals, and

2. Opportunities to publicize this list widely to support appropriate physicians and physician spouses who are aligned with our priorities and encourage financial and social medial support of those candidates, with a report back at the 2027 Annual Meeting.

(Directive to Take Action)

Although testimony offered in response to Resolution 611 was generally supportive, noting opportunities for candidates to connect with other candidates and organizations, concerns were raised over ensuring compliance with legal and tax implications that could impact the AMA's nonprofit status. Further, testimony noted that coordination with various political action committees may be required prior to implementation.

Due to the complexity of this issue, testimony called for referral to assess potential risks and determine an appropriate path forward. Your Reference Committee concurs that further study is warranted.

A proffered amendment called for the development of a scorecard highlighting election outcomes for physicians and physician spouse candidates with a report to be presented at the 2026 Interim meeting. While the sentiment was generally favorable, the AMA's report development process and availability of data were noted as issues of concern.

Further, releasing details on AMPAC contributions would interfere with the business decisions of a separate entity and contribute to perceived inequity among candidates due to varied donation totals. Your Reference Committee believed it was appropriate to delete the request for this information.

Accordingly, your Reference Committee proposed amended language to support this effort while considering issues noted during testimony. Your Reference Committee believes that presenting an annual scorecard on the AMA's website would be an appropriate alternative to developing a preliminary report for the 2026 Interim meeting.

Therefore, your Reference Committee recommends that Resolution 611 be adopted as amended.

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(18) RESOLUTION 613 - PRESERVING INSTITUTIONAL EQUITY AND INCLUSIVITY EFFORTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 613 be referred.

HOD ACTION:
Alternate Resolution 613 adopted in lieu of Resolution 613.

RESOLVED, that our AMA preserve and maintain its "Optimal Health Outcomes"-focused resources on the AMA website and the AMA EdHub, and be it further

RESOLVED, that our AMA increase transparency regarding resource alterations or removal, and be it further

RESOLVED, that, when possible, our AMA limit substantive alterations to "Optimal Health Outcomes"-focused resources unless dictated by AMA policy.

RESOLVED, that our American Medical Association's Board of Trustees ensure the restoration of resources that have been removed, with exceptions to archive rather than completely remove those resources that are out of date, being updated, or need to be removed for protection of parties involved in their creation (Directive to Take Action); and be it further

RESOLVED, that our AMA, when making changes to website resources, provide transparent communication and appropriate notice to all membership with forewarnings to members and staff involved in creation of those efforts that are being removed or altered or archived, even if temporarily, and provide such communication retrospectively for those resources which have been modified already without AMA policy impetus to do so (Directive to Take Action); and be it further

RESOLVED, that our AMA only make changes up to and including removal to publicly available resources in line with policy changes. (Directive to Take Action)

Testimony in response to Resolution 613 was supportive and cited the importance of retaining resources related to diversity, equity and inclusion. It was further noted that the availability of these resources is in alignment with AMA policy and demonstrates its commitment to these efforts.

A proffered amendment outlined specific communication protocols and remedies to address removal of resources related to diversity, equity and inclusion. Although testimony was mostly supportive, your Reference Committee notes potential difficulties with

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operationalizing this amendment: reinstating certain resources could present compliance issues; identifying proper parties originally involved in the creation and maintenance of equity-focused resources; and determining the appropriate stimulus for communicating website changes to membership, staff and other parties.

While testimony supported transparent communication regarding changes to content and resource availability, there was concern that the process outlined in the second Resolve may be too restrictive, especially in the case of routine website updates. Therefore, your Reference Committee recommends referral for a report back.

(19) RESOLUTION 616 - HUMANITARIAN AND MEDICAL AID SUPPORT TO PALESTINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 616 be referred.

HOD ACTION:
Resolution 616 referred.

RESOLVED, that our American Medical Association supports efforts to contribute funds to support the humanitarian crisis in Gaza (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for continuous support of organizations providing humanitarian missions and medical care to Palestinian refugees in Palestine, in nearby countries, and/or in the US (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an early implementation of mental health measures and address war-related trauma and post-traumatic stress disorder when dealing with Palestinian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly. (Directive to Take Action)

Testimony in response to Resolution 616 was mixed.

Several individuals who testified recommended amending existing AMA policy to generalize humanitarian principles and interventions for all populations affected by armed conflict, rather than adopting conflict-specific resolutions, thereby taking a more universal approach.

Since current Policy D-65.984, “Humanitarian and Medical Aid Support to Ukraine,” is not under consideration at this time, your Reference Committee agrees with the proposal of melding this resolution with existing policy. Therefore, your Reference Committee recommends that Resolution 616 be referred for a report back as a mechanism to accomplish this goal.

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RECOMMENDED FOR REFERRAL FOR DECISION

(20) RESOLUTION 618 - ENDING AMA INVESTMENT IN WEAPONS MANUFACTURERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 618 be referred for decision.

HOD ACTION:
Resolution 618 referred for decision.

RESOLVED, that our American Medical Association divest from all companies that derive a majority of their revenue from the manufacturing of weapons, cluster munitions, chemical, biological, or nuclear weapons, or key component of these weapons (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates at A-27 on what progress has been made towards divestment. (Directive to Take Action)

Testimony in response to Resolution 618 was mixed. The Board of Trustees cited a previous analysis conducted in response to a request to divest from the fossil fuel industry, in which outside counsel determined that investment restrictions would unduly interfere with the Board's fiduciary duty to manage organizational assets responsibly. Key concerns included the complexity and operational challenges of divesting from a narrow set of investments within diversified funds, the risk of negatively impacting financial returns and increasing portfolio risk, the possibility of breaching the Board's fiduciary duty by allowing non-financial motives to influence investment decisions, and the practical difficulty of consistently defining and applying terms such as "majority of revenue," "key component," and the concern that the term "weapons" has broad implications in its inclusivity beyond conventional firearms.

Your Reference Committee acknowledges the positive intent of Resolution 618 but believes the potential for significant interference with fiduciary responsibilities as well as the previous legal and financial analysis justify referring to the AMA Board of Trustees.

Therefore, your Reference Committee recommends that Resolution 618 be referred for decision.

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RECOMMENDED FOR NOT ADOPTION

(21) RESOLUTION 606 - FURTHER ENABLING AMA BOT EXPEDIENCY FOR ACTIONS, ADVOCACY, AND RESPONSES DURING URGENT SITUATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 606 not be adopted.

HOD ACTION:
Resolution 606 not adopted.

RESOLVED, that our American Medical Association amend G.600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read as follows:

8. Our AMA shall develop such processes as the BOT deems appropriate to ensure the BOT is apprised on a weekly basis of AMA activity related to the policy actions and directives adopted by the House of Delegates that occurred through:

   a. the formal meetings and notable informal meetings with stakeholders and policymaking entities;
   b. the formal correspondence, comments, or testimony submitted by the AMA;
   c. notable informal correspondence exchanged between AMA management and policymakers or other stakeholders;
   d. the relevant correspondence received from the leadership of entities in organized medicine, the federal government, or any other relevant sector; and
   e. any developments with respect to new or existing policy concepts, policy negotiations, or policy proposals on transformational national health policies.

9. Our AMA BOT will be directly informed and consulted prior to the onset of and throughout the course of any negotiations between AMA management and federal policymakers on transformational changes to national health policies, such as alteration of the methodology for reimbursing physicians under any component of the public sector payer apparatus or the sunsetting or creation of any program that is likely to impact more than half of all Medicare participating providers. (Modify Current HOD Policy)

Testimony in response to Resolution 606 was limited and mixed.

Opponents argued that although the House of Delegates sets policy, prescribing specific operational and reporting processes for the Board of Trustees and management exceeds the House of Delegates' established authority and could undermine effective governance by blurring institutional responsibilities. They emphasized that flexibility, responsiveness, and mutual trust are crucial, especially during rapidly evolving federal policy discussions,

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and that many goals identified in the resolution are already addressed through existing processes.

Supporters, on the other hand, contend that the House of Delegates' authority is not limited to broad policy direction but extends to issuing specific directives, including operational oversight. They maintain that the resolution arose from concerns about inadequate transparency during critical Medicare negotiations and is necessary to ensure meaningful oversight on transformational federal policy changes affecting physicians.

Nevertheless, the prevailing sentiment is that this item represents a complex and challenging governance matter that falls outside the House of Delegates' purview and would be better handled within the established institutional framework. Therefore, your Reference Committee recommends that Resolution 606 not be adopted.

(22) RESOLUTION 614 - INCLUSIVE POLICY LANGUAGE FOR OLDER ADULTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 614 not be adopted.

HOD ACTION:
Resolution 614 not adopted.

RESOLVED, that our American Medical Association will instruct all future policy language to use terms for those over the age of 65 to be "older persons", "older people", "older adults", "older patients", "older individuals", "persons 65 years and older", "the older population", or preferred terminology from a specific group of older adults (e.g., Native American elders), in order to avoid a connotation of discrimination and negative stereotypes. (New HOD Policy)

Testimony in response to Resolution 614 was mostly in opposition, citing concerns that "senior" is a widely used and accepted term while alternative language such as "older adult" may lead to ambiguity.

Limited testimony offered in support noted that language can influence perceptions and behavior towards others. Further testimony indicated that the language offered in this resolution aligns with guidance on inclusive language.

Your Reference Committee recommends that Resolution 614 not be adopted.

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(23) RESOLUTION 617 - REEVALUATION OF AMA POLICY REGARDING SUPPORT FOR SPECIFIC NATIONAL MEDICAL ASSOCIATIONS IN THE WORLD MEDICAL ASSOCIATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 617 not be adopted.

HOD ACTION:
Resolution 617 not adopted.

RESOLVED, that our American Medical Association rescind AMA policy D-250.990 "Israeli Medical Association" which states "Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association" (Rescind HOD Policy); and be it further

RESOLVED, that our AMA's position on business in the World Medical Association (WMA) related to applications for constituent membership, or discipline or termination for current constituent members shall be based on the prevailing evidence at the time. (New HOD Policy)

Testimony in response to Resolution 617 was largely opposed to rescinding Policy D-250.990, "Israeli Medical Association." Testimony included that removing support for the Israeli Medical Association's membership in the World Medical Association at this time could be interpreted as endorsing its exclusion, which conflicts with AMA's policies against censure based on government actions.

Given that Policy D-250.990 was first adopted in 2007, and later reaffirmed in 2017, your Reference Committee noted that our AMA's position on the Israeli Medical Association's membership in the World Medical Association has existed for 19 years; therefore, the unintended consequence highlighted by the testimony is a viable concern.

Therefore, your Reference Committee recommends that Resolution 617 not be adopted; thereby, allowing Policy D-250.990 to remain in place at this time and be naturally subject to the AMA's Policy sunset review process at the 2027 Annual Meeting.

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RECOMMENDED FOR FILING

(24) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION:
Board of Trustees Report 1 filed.

The Consolidated Financial Statements for the years ended December 31, 2025 and 2024 and the Independent Auditor's report have been included in the 2025 Annual Report, that is included in the Handbook mailing to members of the House of Delegates.

The overall response to Board of Trustees Report 1 was positive, with supportive remarks on the accessibility and inclusion of financial documents. The testimony also included constructive inquiry focused on financial clarity and organizational stewardship, particularly regarding investment returns, administrative expenses, and revenue growth.

Your Reference Committee recommends that Board of Trustees Report 1 be filed.

(25) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - UPDATE ON CLRPD EVALUATION OF THE STRUCTURE OF THE HOUSE OF DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that Council on Long Range Planning and Development Report 1 be filed.

HOD ACTION:
Council on Long Range Planning and Development Report 1 filed.

The Council on Long Range Planning and Development Report 1 is an informational report that outlines ongoing evaluation of the AMA House of Delegates structure, aiming to address rapid delegate growth, efficiency, and fair representation. Proposed changes under consideration include pausing delegate growth, revising apportionment ratios, and considering a fixed House size using mathematical models such as the Method of Equal Proportions. Stakeholder feedback indicates support for equitable, simple reforms but

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highlights concerns about preserving diversity and representation, with ongoing efforts focused on consensus-building and transparency.

Testimony in response to the Council on Long Range Planning and Development Report 1 primarily focused on details related to the Council's evaluation on the structure of the House of Delegates. Further testimony indicated the report was extracted to encourage discussion and identify considerations for future discussion.

It was noted that a series of town halls will be hosted on June 29, July 6 and July 8 with the goal of providing education, collecting feedback on proposals under consideration, and working toward building consensus.

Limited testimony supported filing of this report. Your Reference Committee concurs and recommends that CLRPD Report 1 be filed.

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This concludes the report of Reference Committee F. I would like to thank Emily D. Briggs, MD, MPH, Richard A. Geline, MD, Hillary Johnson-Jahangir, MD, PhD, MS, Jayme N. Looper, MD, MSE, Jayesh B. Shah, MD, MHA, Yasser F. Zeid, MD, MHA, and all those who testified before the Committee.

Emily D. Briggs, MD, MPH
American Academy of Family Physicians

Jayme N. Looper, MD, MSE
American Society of Anesthesiologists

Richard A. Geline, MD (Alternate)
Illinois

Jayesh B. Shah, MD, MHA
Texas

Hillary Johnson-Jahangir, MD, PhD, MS
American Academy of Dermatology Association

Yasser F. Zeid, MD, MHA
Texas

Robert A. Gilchick, MD, MPH
American College of Preventive Medicine
Chair

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DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee G

Robert Dannenhoffer, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 22 – Comprehensive AMA Policy Publication Regarding Employed Physicians
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2016 House Policies
3. Council on Medical Service Report 4 – Expanding Medicare Coverage of Medical Nutrition Therapy
4. Council on Medical Service Report 7 – Private Insurance Coverage of Anti-Obesity Medications
5. Resolution 704 – Advocating Against Automatic Refill Requests
6. Resolution 708 – Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
7. Resolution 711 – Oppose Denials Based on Origin of Referral
8. Resolution 712 – Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
9. Resolution 715 – Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 20 – Mitigating the Impact of Excessive Prior Authorization Processes
11. Council on Medical Service Report 9 – Nonprofit Status
12. Resolution 701 – The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
13. Resolution 702 – Physicians Who Do Not Practice in Hospital Setting
14. Resolution 703 – Parity in Pricing for Anti-Obesity Medications
15. Resolution 705 – Recognizing Physicians as Sexual Assault Forensic Examiners
16. Resolution 706 – Discharge Summaries from Skilled Nursing Facilities
17. Resolution 709 – Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
18. Resolution 710 – Parity in Access to Evidence-Based Obesity Treatment
19. Resolution 713 – Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
20. Resolution 714 – Physician Case Log Portability

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RECOMMENDED FOR REFERRAL

21. Council on Medical Service Report 6 – Study of Practice Models for Physicians Performing Procedures Across State Lines
22. Resolution 707 – Malpractice Insurance for Employed Physicians
23. Resolution 717 – Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

24. Resolution 716 – Equal Opportunity for Payment for “On Call” Duty

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RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 22 - COMPREHENSIVE AMA POLICY PUBLICATION REGARDING EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Board of Trustees Report 22 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 is adopted and remainder of Report filed.

The Board of Trustees recommends that the first directive of Policy D-225.971, Comprehensive AMA Policy Publication Regarding Employed Physicians, be rescinded as having been accomplished by this report and that the remainder of the report be filed.

Your Reference Committee heard limited, but supportive, testimony on this report. Thus, your Reference Committee recommends that recommendations in Board of Trustees Report 22 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2016 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 is adopted and remainder of Report filed.

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of the report be filed.

Your Reference Committee heard limited, supportive testimony on Council on Medical Service Report 1. Therefore, your Reference Committee recommends that recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

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(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - EXPANDING MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 is adopted and remainder of Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 116-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognize the benefits and support the use of medical nutrition therapy (MNT) – delivered by a Registered Dietitian Nutritionist, as defined in §1861(v)(2) of the Social Security Act and credentialed by the Commission on Dietetic Registration and in ongoing support with the patient's physician – for the purpose of managing and treating chronic health conditions for which there is evidence of efficacy. (New HOD Policy)
2. That our AMA support the expansion of Medicare coverage and exemption from budget neutrality for evidence-based intensive behavioral and nutritional interventions, including medical nutrition therapy (MNT). (New HOD Policy)
3. That our AMA reaffirm Policy H-160.906, which defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based care. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in Merit-based Incentive Payment System with incentive payments, or implements positive annual physician payment updates. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 4. Testimony indicated that medical nutrition therapy plays a significant role in the treatment of multiple metabolic diseases and should therefore be appropriately covered by Medicare. While one individual expressed their reservations with the exemption of Medicare coverage for medical nutrition therapy from budget neutrality, there was no other testimony on this issue. One individual proffered an amendment to add two recommendations to support equitable coverage of the treatment of eating disorders, which are classified as "serious mental illnesses." The Council on Medical Service noted that the amendment was not germane to the report since the issue falls outside the scope of the referred resolution. A preponderance of testimony supported the report as written with no testimony supporting the amendments. Therefore, your Reference Committee

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recommends that recommendations in Council on Medical Service Report 4 be adopted and remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 7 - PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY MEDICATIONS

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 7 is adopted and remainder of Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Subclauses 1e and 1g of Resolution 230-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support:
    a. Potential innovative payment arrangements to help individuals afford treatment for emerging anti-obesity medications (AOMs);
    b. Pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management, such as glucagon-like peptide-1 and glucose-dependent insulinotropic polypeptide-based medications;
    c. The long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability;
    d. Equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.

    (New HOD Policy)
2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-110.959, which supports efforts to ensure patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, that all patients have access to all prescription drugs necessary to treat their illnesses, and physicians have the freedom to prescribe the most appropriate drug and method of delivery. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy D-330.954, which supports the Centers for Medicare & Medicaid Services (CMS) negotiating pharmaceutical pricing for all applicable medications covered by CMS, AMA working toward the elimination Medicare prohibition on drug price negotiation, and indicates the AMA's support for federal

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legislation giving the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-150.953, which recognizes obesity as a complex health disorder, urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity. (Reaffirm HOD Policy)

Your Reference Committee heard unanimously supportive testimony on Council on Medical Service Report 7. Testimony indicated that the report satisfied the intent of the resolution and approached the complex and dynamic topic of anti-obesity medication coverage with alacrity. Therefore, your Reference Committee recommends that recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(5) RESOLUTION 704 - ADVOCATING AGAINST AUTOMATIC REFILL REQUESTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 704 be adopted.

HOD ACTION: Resolution 704 is adopted.

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 & 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)

Your Reference Committee heard mostly supportive testimony on Resolution 704, with several delegations emphasizing that automatic pharmacy-generated refill requests create unnecessary administrative burden, disrupt workflow, and often occur without patient involvement. Testimony supported an opt-in approach to ensure patient engagement and improve safety, with one delegation raising concerns about potential impacts on access for contraception and proposed an amendment to address those concerns. There was no other testimony in support of the amendment and concerns were expressed that the proposed language could increase administrative burden further without improving access to contraception. Therefore, your Reference Committee recommends that Resolution 704 be adopted.

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(6) RESOLUTION 708 - OPPOSE IMPOSITION OF FEES ON PHYSICIANS FOR ELECTRONIC PAYMENT TRANSFERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 708 be adopted.

HOD ACTION: Resolution 708 is adopted.

RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rule compliant with the Administrative Procedure Act with a notice and comment period preventing the use of virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 708, with multiple delegations emphasizing that fees on electronic payments reduce physician payment and increase administrative burden. Testimony urged adoption to secure enforceable Centers for Medicare & Medicaid Services action, noting that existing policy has been insufficient to address ongoing fee practices and therefore providing testimony against reaffirmation. Your Reference Committee recommends that Resolution 708 be adopted.

(7) RESOLUTION 711 - OPPOSE DENIALS BASED ON ORIGIN OF REFERRAL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 711 be adopted.

HOD ACTION: Resolution 711 is adopted.

RESOLVED, that our American Medical Association advocate against prior authorization denials based solely upon the referring physician or appropriately licensed clinician. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 711, with multiple delegations stating that denials based solely on the referring physician create administrative barriers, delay care, and harm patients. Testimony emphasized the realities of team-based care and the need for decisions based on medical necessity. Several delegations opposed reaffirmation, noting gaps in current policy. Therefore, your Reference Committee recommends that Resolution 711 be adopted.

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(8) RESOLUTION 712 - ADDRESSING THE COMMODITIZATION OF MEDICINE THROUGH RECOGNITION OF THE FULL SCOPE OF PHYSICIAN WORK AND CONTRIBUTIONS

RECOMMENDATION:

Your Reference Committee recommends Resolution 712 be adopted.

HOD ACTION: Resolution 712 is adopted.

RESOLVED, that our American Medical Association advocate that health systems, hospitals, other physician employers, and third-party payors recognize that the profession of medicine is not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and should not be reduced solely to productivity measures (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage employers of physicians to utilize productivity benchmarks, performance expectations, and compensation structures that recognize and integrate the full scope of physician work, including clinical, administrative, educational, and operational responsibilities that may not be fully captured by traditional productivity metrics (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide both employed and independent physicians with appropriate time, resources, compensation, support, and recognition for non-billable work that is essential to patient care, physician well-being, and health system function. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 712. Several delegations provided testimony in favor of the original resolution. There was an amendment offered by an individual; however, there was no further testimony on this amendment. As such, your Reference Committee took this as support for the original language and recommends that Resolution 712 be adopted.

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(9) RESOLUTION 715 - OPPOSE THE LEGAL POSITION THAT VIRTUAL CREDIT CARDS ARE A LEGAL METHOD OF PAYMENT UNDER HIPAA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 715 be adopted.

HOD ACTION: Resolution 715 is adopted.

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)

Your Reference Committee heard uniformly supportive testimony on Resolution 715. The author and multiple delegations emphasized that virtual credit cards impose unnecessary fees on physicians for receiving payment, reducing already limited payment. Testimony reinforced longstanding AMA policy supporting no-fee electronic funds transfer and opposing excessive payment processing fees, underscoring that physicians should not have to pay to get paid. One individual proposed additional amendments regarding HIPAA compliance, but there was testimony provided against the amendments and all other testimony largely supported the resolution as written. Therefore, your Reference Committee recommends that Resolution 715 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(10) BOARD OF TRUSTEES REPORT 20 – MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 20 be amended by addition to read as follows:

2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit.

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 20 is adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

The Board of Trustees recommends the following and the remainder of the report be filed:

1. That the referred resolve clause of Resolution 704-A-25 not be adopted.

2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit.

3. That existing AMA policies H-320.939, "Prior Authorization and Utilization Management Reform", D-320.974, "Insurer Accountability When Prior Authorization Harms Patients", and H-320.950, "Eliminating Precertification" be reaffirmed.

The Board of Trustees recommends the following and the remainder of the report be filed:

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1. That the referred resolve clause of Resolution 704-A-25 not be adopted.
2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians.
3. That existing AMA policies H-320.939, “Prior Authorization and Utilization Management Reform”, D-320.974, “Insurer Accountability When Prior Authorization Harms Patients”, and H-320.950, “Eliminating Precertification” be reaffirmed.

Your Reference Committee heard mixed, but mostly supportive testimony on Board of Trustees Report 20. There was confusion regarding which of the original resolve clauses were referred, which was clarified by the Board. In response to testimony asking for a class action lawsuit to be explored, the Board offered an amendment to recommendation 2, noting that the report did not conclusively determine that a class action lawsuit was impossible, only that it would be difficult. Subsequent testimony supported this amendment. Therefore, your Reference Committee recommends that recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

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(11) COUNCIL ON MEDICAL SERVICE REPORT 9 - NONPROFIT STATUS

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in Council on Medical Service Report 9 be amended by addition to read as follows:

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.
5. Our AMA advocates for the development of ~~a~~ transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
6. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.

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7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 9 is adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL POLICIES, H-155.954

1. **Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.**
2. **Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.**
3. **Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.**
4. **Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.**
5. **Our AMA advocates for the development of transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.**
6. **Our AMA advocates for transparency and consistency regarding governmental oversight of nonprofit hospitals, enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.**
7. **Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA),**

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including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

8. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
9. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
10. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
11. Our AMA advocates for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities and eligibility for nonprofit status.
12. Our AMA advocates for the development of ~~a~~ transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
13. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.
14. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

Your Reference Committee heard overall supportive testimony on Council on Medical Service Report 9, highlighting its relevance and timeliness. There were amendments offered in testimony to broaden the scope of the report. The Reference Committee agreed with the Council's response highlighting that several of the topics recommended for addition were addressed in the body of the report and concurred with testimony to include only the amendment regarding consideration of social drivers of health when determining community benefits. Your Reference Committee believes this language broadens the recommendations while remaining in scope of the original report and thus recommends that recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

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(12) RESOLUTION 701 - THE CRISIS IN THE AVAILABILITY OF PRIMARY CARE: HALT THE REQUIRED PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~will~~ advocate ~~for the immediate discontinuation of required participation~~ to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate. ~~arrangements for practices with ten or fewer physicians, regardless of practice revenue.~~ (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 701 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 701 be changed to read as follows:

PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

HOD ACTION: Resolution 701 is adopted as amended.

ADOPTED LANGUAGE:

NEW TITLE: PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

RESOLVED, that our American Medical Association advocate to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to

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small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate. (Directive to Take Action)

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)

Your Reference Committee heard supportive testimony for Resolution 701. Testimony suggested that the resolution could contribute to small practice viability by ensuring reasonable applications of value-based programs. One delegation proffered an amendment highlighting the complex designations of small practices and that a limited capacity to participate might not be limited to practice size but could include location, Medicare revenue, or professional shortage areas. Additional testimony supported the amended language and suggested a corresponding title change so that the resolution apply to all small practices regardless of specialty. Therefore, your Reference Committee recommends that Resolution 701 be adopted as amended with a title change.

(13) RESOLUTION 702 - PHYSICIANS WHO DO NOT PRACTICE IN HOSPITAL SETTING

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 702 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.

(Modify Current HOD Policy)

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RECOMMENDATION B:

Your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. **Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.**
2. **Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.**
3. **Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.**

(Modify Current HOD Policy)

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate that hospital privileges not be a requirement for insurance network participation.

(Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 702, with the suggestion of a clarifying amendment. The proposed amendment broadened the language to include both federal and state advocacy efforts and was supported by the authors of the resolution. Testimony was supportive of the intent of the original resolution as well as the amended language since these requirements can create burdens on physicians and can also reduce access to care for patients; therefore, your Reference Committee recommends that Resolution 702 be adopted as amended.

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(14) RESOLUTION 703 - PARITY IN PRICING FOR ANTI-OBESITY MEDICATIONS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 703 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Resolution 703 be changed to read as follows:

MEDICATION PRICING PARITY

HOD ACTION: Resolution 703 is adopted as amended.

ADOPTED LANGUAGE:

NEW TITLE: MEDICATION PRICING PARITY

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)

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)

Your Reference Committee heard universal support for Resolution 703. Testimony indicated that while telehealth is a valuable tool, it should not replace, disincentivize, or fragment in-person care. Furthermore, testimony highlighted that a title change may be warranted so that the resolution can apply to all medications. Therefore, your Reference Committee recommends that Resolution 703 be adopted with a change in title.

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(15) RESOLUTION 705 - RECOGNIZING PHYSICIANS AS SEXUAL ASSAULT FORENSIC EXAMINERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 705 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
    a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
    b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
    c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
    d. be informed of these rights and the policies governing the sexual assault evidence kit; and
    e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased patient access to Sexual Assault Medical ~~Nurse~~ Forensic Examiners~~, and other trained and qualified clinicians, in the emergency department~~ for sexual assault medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;

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a. the timely processing of all sexual examination kits upon patient consent;
b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
c. additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of ~~Sexual Assault Nurse Examiner and~~ Sexual Assault Medical Forensic Examiners ~~providers~~. (Modify Current AMA Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 705 be adopted as amended.

HOD ACTION: Resolution 705 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

SEXUAL ASSAULT SURVIVORS, H-80.999

1. **Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.**
2. **Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:**
   a. **receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;**
   b. **preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;**
   c. **notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;**
   d. **be informed of these rights and the policies governing the sexual assault evidence kit; and**
   e. **access to emergency contraception information and treatment for pregnancy prevention free of charge.**
3. **Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.**

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4. Our AMA will advocate for increased patient access to Sexual Assault Medical Forensic Examiners for sexual assault medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;
a. the timely processing of all sexual examination kits upon patient consent;
b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
c. additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Medical Forensic Examiners.
(Modify Current AMA Policy)

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

SEXUAL ASSAULT SURVIVORS, H-80.999
1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
d. be informed of these rights and the policies governing the sexual assault evidence kit; and
e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group

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established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased patient access to Sexual Assault ~~Nurse~~ Forensic Examiners~~, and other trained and qualified clinicians,~~ in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;
   a. the timely processing of all sexual examination kits upon patient consent;
   b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
   c. additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of ~~Sexual Assault Nurse Examiner and~~ Sexual Assault Medical Forensic Examiners ~~providers~~.
(Modify Current AMA Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 705. Testimony indicated that the resolution enhances existing policy by ensuring the AMA is aligned with currently accepted terminology. One individual proposed several amendments, suggesting that the updates more accurately capture the limited credentialling of sexual assault nurse examiners (SANEs), trauma informed care may be performed outside of the emergency department, and medical forensic examinations constitute a broader term not solely representative of sexual assault examinations. The author testified in support of the amendment recognizing that trauma informed care may be performed outside the emergency department but clarified that SANE is a form of sexual assault forensic examiner (SAFE) and was correctly categorized. Furthermore, the author agreed that there is a distinction between medical forensic examinations and sexual assault examinations and proposed a compromised amendment utilizing the current Department of Defense terminology "sexual assault medical forensic examinations". Your Reference Committee agrees that the compromised language most effectively updates AMA policy and concurs with the author that SANEs are a form of SAFEs and were correctly identified. Furthermore, your Reference Committee recognizes that sexual assault may occur outside of the emergency department, and, therefore, recommends that Resolution 705 be adopted as amended.

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(16) RESOLUTION 706 - DISCHARGE SUMMARIES FROM SKILLED NURSING FACILITIES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association educate physicians ~~their members~~ as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 706 be amended by addition of a new resolve clause to read as follows:

RESOLVED, that our AMA advocate that CMS enforce its existing regulations on timely and comprehensive discharge summaries.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association educate physicians as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

RESOLVED, that our AMA advocate that CMS enforce its existing regulations on timely and comprehensive discharge summaries.

RESOLVED, that our American Medical Association educate their members as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

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Your Reference Committee heard limited testimony in support of the intent of Resolution 706, but with two amendments offered. Testimony supported the goal of the resolution to improve continuity of care and communication during transition from skilled nursing facilities to outpatient settings and suggested an amendment to clarify where the proposed education should be targeted. A second amendment was proposed to ask the AMA to advocate that the Centers for Medicare & Medicaid Services enforce existing guidelines. Your Reference Committee did not believe that the second part of the proposed amendment for the new resolve clause, which read "as policies without implementation or accountability mechanisms often fail to improve real-world practice" was necessary to include, as it was mostly narrative and will not significantly impact the potential action the AMA would take. Therefore, your Reference Committee recommends that Resolution 706 be adopted as amended.

(17) RESOLUTION 709 - REQUIRING TRANSPARENCY AND ACCOUNTABILITY WHEN INSURERS AND THIRD-PARTY ADMINISTRATORS REQUIRE UTILIZATION REVIEW, THEREBY PRACTICING MEDICINE

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 709 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction ~~New York State~~ and therefore, accountable to ~~New York State authorities~~ appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 709 be adopted as amended.

HOD ACTION: Resolution 709 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA),

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and allow for accountability should the decision be called into question (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction and therefore, accountable to appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RESOLVED that our American Medical Association amend their Policy H-285.939 as follows:

MANAGED CARE MEDICAL DIRECTOR LIABILITY, H-285.939
Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.

1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions.

2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.

3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

(Modify Current HOD Policy)

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA), and allow for accountability should the decision be called into question (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in New York State and therefore, accountable to New York State authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RESOLVED that our American Medical Association amend their Policy H-285.939 as follows:

MANAGED CARE MEDICAL DIRECTOR LIABILITY, H-285.939
Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.
1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical

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directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions.
2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.
3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.
(Modify Current HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 709, with many calling out the inappropriate reference to a specific state in the second resolve clause. There were several amendments proposed to address these concerns. Other testimony emphasized that utilization review decisions reflect medical judgment and should be recognized as the practice of medicine, requiring transparency and accountability. Those providing testimony highlighted the need for disclosure of reviewer identity, licensure, and credentials, and supported amendments to ensure national applicability. Therefore, your Reference Committee recommends that Resolution 709 be adopted as amended.

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(18) RESOLUTION 710 - PARITY IN ACCESS TO EVIDENCE-BASED OBESITY TREATMENT

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 710 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of ~~anti-obesity~~ medications for anti-obesity indications ~~(Section 1927(d)(2) of the Social Security Act), and further advocate that all state Medicaid programs be required to include FDA-approved anti-obesity medications on their formularies as a condition of federal matching funds~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends Resolution 710 be amended by addition of a new resolve clause to read as follows:

RESOLVED, that our AMA affirm that treatment decisions for patients with obesity — including the sequencing and selection of pharmacologic therapy, behavioral intervention, and bariatric or metabolic surgery — should be made through individualized, evidence-based, shared decision-making between the physician and patient, free from payer-imposed treatment hierarchies or mandatory sequencing requirements. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 710 be adopted as amended.

HOD ACTION: Resolution 710 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease without exclusionary carve-outs, annual or lifetime caps specific to obesity,

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or "fail first"/step therapy requirements not applied to comparable chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of medications for anti-obesity indications (New HOD Policy); and be it further

RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage to evidence-based obesity treatment or insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level. (New HOD Policy)

RESOLVED, that our AMA affirm that treatment decisions for patients with obesity — including the sequencing and selection of pharmacologic therapy, behavioral intervention, and bariatric or metabolic surgery — should be made through individualized, evidence-based, shared decision-making between the physician and patient, free from payer-imposed treatment hierarchies or mandatory sequencing requirements. (New HOD Policy)

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease without exclusionary carve-outs, annual or lifetime caps specific to obesity, or "fail first"/step therapy requirements not applied to comparable chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of anti-obesity medications (Section 1927(d)(2) of the Social Security Act), and further advocate that all state Medicaid programs be required to include FDA-approved anti-obesity medications on their formularies as a condition of federal matching funds (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage to evidence-based obesity treatment or insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices (New HOD Policy); and be it further

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RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 710. Testimony indicated that obesity continues to be a significant challenge for much of the population and that emerging therapies may help address it. The Council on Medical Service raised concerns about the second resolve clause and proposed revised language, noting that requiring state Medicaid programs to include anti-obesity medications (AOMs) on their formularies as a condition of federal matching funds could create unintended fiscal consequences. Additional testimony agreed with the Council's amendment. Online testimony from an individual proposed an amendment to the fourth resolve clause, suggesting that surgery should not automatically be treated as the preferred next step before adequate trials of modern medical therapy. However, your Reference Committee heard testimony at the in-person hearing offering an alternate amendment that supported the original language of the fourth resolve clause and adding a new fifth resolve clause. There was subsequent testimony in support of these proposed amendments. Therefore, your Reference Committee recommends that Resolution 710 be adopted as amended.

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(19) RESOLUTION 713 - REDUCING PRIOR AUTHORIZATION DELAYS TO IMPROVE ACCESS TO NEUROMODULATION AND NON-OPIOID PAIN THERAPIES

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 713 be deleted:

~~RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior authorization processes across payers, including response timelines that do not exceed 72 hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 713 be adopted as amended.

HOD ACTION: Resolution 713 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)

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RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior authorization processes across payers, including response timelines that do not exceed 72 hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and be it further

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 713, with one individual speaking in favor of adoption with amendment. There was no testimony to support reaffirmation. Testimony emphasized that prior authorization delays uniquely affect chronic pain care by limiting access to evidence-based non-opioid therapies and may worsen outcomes or increase reliance on opioids. The testimony supported removing prescriptive timeline language. Therefore, your Reference Committee recommends that Resolution 713 be adopted as amended.

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(20) RESOLUTION 714 - PHYSICIAN CASE LOG PORTABILITY

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 714 be amended by addition and deletion to read as follows:

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards ~~not to exceed five (5) business days~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 714 be adopted as amended.

HOD ACTION: Resolution 714 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards (Directive to Take Action); and be it further

RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)

RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further

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RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, not to exceed five (5) business days (Directive to Take Action); and be it further

RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 714. One delegation provided testimony in favor of the resolution and proposed an amendment to lengthen the five-business day timeline, but no alternative timeline was suggested. Since no timeline was offered to replace the five-business days cited in the original resolution, your Reference Committee presents language that it believes captures the intent of the need for an extension; however, the Reference Committee would be open to further amendments if a specific timeline would be more appropriate. Your Reference Committee recommends that Resolution 714 be adopted as amended.

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RECOMMENDED FOR REFFERAL

(21) COUNCIL ON MEDICAL SERVICE REPORT 6 - STUDY OF PRACTICE MODELS FOR PHYSICIANS PERFORMING PROCEDURES ACROSS STATE LINES

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 6 be referred.

HOD ACTION: Council on Medical Service Report 6 is referred.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care:
    a. A transfer agreement with a physician or physician group licensed in the patient's state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician with no admitting privileges to the local hospital.
    b. A referral system with a local physician, physician practice, or other facility for appropriate treatment should be established if a patient's conditions or symptoms are beyond the scope of services provided by the ASC or OBL.
    c. Transfer agreements and backup plans should be coordinated between physicians.
        i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care.
        ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed.
        iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety.
    d. Protocols for ensuring continuity of care with physicians in the local community should be established.
    e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.
    f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.

    (New HOD Policy)
2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians

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performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Council on Medical Service Report 6. Online testimony had limited support, while in-person testimony favored referral. Questions were raised as to whether this report should be referred to specifically include considerations for both rural and reproductive healthcare. The Council on Medical Service offered amendments to address the concerns raised; however, testimony continued to support referral. Your Reference Committee recommends that recommendations in Council on Medical Service Report 6 be referred.

(22) RESOLUTION 707 - MALPRACTICE INSURANCE FOR EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 707 be referred.

HOD ACTION: Resolution 707 is referred.

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)

Your Reference Committee heard mixed testimony that supported the spirit of Resolution 707 but recommended that this resolution be referred in order to carefully consider the language. Most testimony agreed that malpractice insurance is an important issue, especially for employed physicians and young physicians. Testimony asked for a future report to consider the impact on private practices, explore potential resolutions for entities that have collapsed, and explore differences in coverage options between states. Hearing the concerns raised, the Reference Committee believes that this topic could benefit from further study and thus recommends referral.

(23) RESOLUTION 717 - ADVOCACY FOR A FAILURE-PROOF NATIONAL CENTRALIZED ELECTRONIC TRANSACTION CLEARINGHOUSE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 717 be referred.

HOD ACTION: Resolution 717 is referred with report back at A-27.

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RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain only one standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier such as a health plan identifier (HPID) and/or national provider identifier (NPI). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 717. There was support for the resolution, emphasizing the need for a standardized national clearinghouse and identifier framework to reduce fragmentation and administrative burden, particularly for small and independent practices. Further testimony supported the intent but recommended study, and the Council on Medical Service testified in opposition to the resolution, noting that the AMA previously supported rescission of the Health Plan Identifier after significant operational and implementation problems emerged and that the Centers for Medicare & Medicaid Services is pursuing more effective modern interoperability approaches. Your Reference Committee believes this topic could benefit from further study and thus recommends that Resolution 717 be referred.

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(24) RESOLUTION 716 - EQUAL OPPORTUNITY FOR PAYMENT FOR "ON CALL" DUTY

RECOMMENDATION:

Your Reference Committee recommends that Policies H-130.948, D-130.963, and D-130.965 be reaffirmed in lieu of Resolution 716.

HOD ACTION: Resolution 716 is referred.

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)

Your Reference Committee heard testimony on Resolution 716 that mostly supported reaffirmation. One delegation in support of the resolution as written highlighted that inadequate payment and resource support for “on call” inpatient and emergency care has led to a lack of specialists required to treat patients. However, the author agreed that reaffirmation of existing policy is the most prudent approach as there is sufficient AMA policy that addresses this resolution. The author reiterated support for reaffirmation at the in-person hearing in addition to other testimony supporting reaffirmation. Your Reference Committee agrees that there is ample policy that covers the resolution and recommends that Policies H-130.948, D-130.963, and D-130.965 be reaffirmed in lieu of Resolution 716.

ON-CALL PHYSICIANS H-130.948
Our AMA:
(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that

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are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.
(CMS Rep. 3, I-99; Reaffirmation A-00; Modified: Sub. Res. 217, I-00; Reaffirmation I-01; Reaffirmation A-07; Appended and Reaffirmed: CMS Rep. 1, I-09; Modified: Res. 818, I-17; Reaffirmed: Res. 824, I-24)

ON-CALL AND EMERGENCY SERVICES PAY D-130.963
Our AMA will develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.
(Res. 818, I-17)

ON-CALL COVERAGE MODELS D-130.965
Our American Medical Association will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to

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unrealistic and unduly burdensome on-call demands, and educate AMA physician members regarding these options. (Res. 722, A-13; Reaffirmed: CMS Rep. 01, A-23)

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This concludes the report of Reference Committee G. I would like to thank Anna Brown, MD, MPhil, Bill David, MD, PhD, Rafael Haciski, MD, Debra Lupeika, MD, Man-Kit Leung, MD, Brian Privett, MD, and all those who testified before the Committee.

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