

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Betty Chu, MD, MBA, Chair:

1. HEALTH SAVINGS ACCOUNT REFORM

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS 1-11 ADOPTED AS FOLLOWS
RECOMMENDATION 12 REFERRED
REMAINDER OF REPORT FILED**

*See Policies H-165.818, H-165.828, H-165.833, H-165.852,
H-290.972 and H-385.912*

At the 2024 Interim Meeting, the House of Delegates referred Resolution 803-I-24, “Health Care Savings Account Reform,” which was sponsored by the New England Delegation and asked the American Medical Association (AMA) to:

Advocate for the revision of Health Savings Accounts (HSAs) to: (1) permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans; (2) permit contributions to the accounts of dependents, including children and spouses; (3) permit contributions from Medicare and Medicaid enrollees; (4) permit the payment of health, dental, and vision insurance premiums from HSAs; (5) permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion; (6) prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and (7) ensure that the expansion of the role and functions of HSAs is complementary to and does not replace health insurance.

Additionally, a proposed amendment was referred with this resolution. The amendment asked the AMA to support expanding choice and competition on Affordable Care Act (ACA) Marketplaces by automatically placing leftover ACA premium tax credits into an HSA when a selected plan's premium is lower than the premium tax credit.

This report considers the referred, proposed changes to HSAs; summarizes relevant AMA policy; and makes several new policy recommendations.

BACKGROUND

An HSA pairs with an HSA-eligible health plan (typically a high-deductible health plan [HDHP]) and is a tax-advantaged way to save money for qualified medical expenses. HSAs are closely tied to United States tax code and have many guidelines and regulations they must follow as a result. Pre-tax dollars can be saved in an HSA and the funds can be used at any time in a person's life to pay for co-pays, prescriptions, dental care, contacts and eyeglasses, bandages, x-rays, and other qualified medical expenses as defined by the Internal Revenue Service (IRS).¹ Notably, insurance premiums are not considered qualified medical expenses (with the exception of Medicare premiums after age 65).² As long as the funds are used for qualified expenses, an individual will not owe taxes on the money when it is taken out of the account. Employers can contribute to employees' HSAs, and like a 401(k) account, the money remains with the employee, even if they leave their job. Investing HSA funds is also possible and can help build a nest egg for health expenses later in life when needs may be greater. In 2023, there were 36 million active HSA accounts that reported holding over \$116 billion in assets. This represents a 500 percent increase since 2013.³

Starting at age 65, there is no penalty for withdrawing HSA funds for non-qualified medical expenses, but income taxes will be owed on the amount withdrawn. Before the age of 65, income taxes plus a 20 percent penalty must be paid on withdrawals not used for qualified medical expenses.

An individual can contribute to an HSA if: 1) they are not enrolled in a health plan sponsored by their spouse or parent that is not an HSA-eligible health plan; 2) they have no other health coverage (with some exceptions); 3) they are not enrolled in Medicare; and 4) they cannot be claimed as a dependent on someone else's tax return.^{4,5}

There are several advantages to an HSA:

- Contributions can be deducted from your taxes.
- Employers can contribute to employee HSAs, similar to 401(k) accounts.
- HSA funds can be invested to grow more wealth. Interest and other earnings on the account are tax free.
- HSA accounts belong to an individual, not an employer, and remain with the individual even if they leave their job.
- Starting at age 65 there is no penalty for using HSA funds for non-qualified medical expenses.
- HSAs can help bridge the gap to Medicare coverage for those who retire before the age of 65.
- HSAs can be used to pay Medicare premiums and long-term care insurance policies.
- HSA funds can be passed to spouses and heirs after death.

Conversely, HSAs are considered regressive because the financial advantages they offer increase as the owner of the account's income and tax rate rises.⁶ Tax exemptions for health spending are regressive for at least three reasons: higher income people are more likely to use the accounts, are more likely to exempt larger amounts, and have higher marginal tax rates. HSAs also provide an advantage to those with higher incomes since they are more likely able to navigate complex tax rules to maximum advantage.⁷ An analysis of 2017 IRS data found that tax returns exceeding \$500,000 in adjusted gross income were the most likely to report individual HSA contributions and returns between \$200,000 and \$1 million were the most likely to report employer HSA contributions. HSA contributions declined as income declined and only a small percentage of low-income tax returns showed contributions to an HSA.⁸

Another characteristic, and possible disadvantage, of HSAs is that they are only available to those that have qualifying HDHPs. Over the years, HDHPs have become a more common employer-sponsored health insurance offering. Among workers with HDHPs, 52 percent had plans with HSAs while eight percent participated in plans with Health Reimbursement Arrangements (HRAs), figures that varied considerably between high and low wage employees. Among workers in the lowest 25 percent wage category, 32 percent had plans with HSAs and 12 percent had HRAs. Among workers in the highest 25 percent wage category, 66 percent had plans with HSAs and seven percent had HRAs.⁹ More workers are now covered by HDHPs, which typically have higher deductibles and lower premiums when compared to traditional plans. Such plans generally require patients to pay the full cost of health services and medications until deductibles are met; however, most HDHPs exclude a variety of preventive services from the deductible. Although an HDHP's lower premium may be attractive to some people, the responsibility for out-of-pocket expenses becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs when they need access to care.¹⁰

HSAs are often not a viable option for those who are uninsured and cannot afford coverage and are often out of reach for people with low and moderate incomes.¹¹ The arrangement is much more feasible for high earners. A 2024 study in *Health Affairs* found that there are racial and ethnic wealth disparities between families with private insurance and those in HDHPs – with or without an associated HSA.¹² Research shows that HSAs are distributed unevenly across race and ethnicity. Latino and Black individuals are about half as likely to have HSAs than are white and Asian individuals.¹³ Additionally, HSAs tend to benefit patients that are overall healthy compared to those that have chronic care needs or other large medical expenses. HSAs must be paired with a qualifying HDHP, which can also impact patients' medical decision-making. According to a literature review conducted by *Health Affairs* in 2017, HDHPs did achieve policymakers' goal of reducing health care costs but also had an adverse effect on patient use of preventive services, screenings, and medication adherence.¹⁴

The final language of the 2025 Federal Budget Reconciliation Bill (commonly known as the “One Big Beautiful Bill Act [OBBBA]”) allows individual market bronze and catastrophic plans to be treated as HSA-eligible HDHPs. This will go into effect on January 1, 2026, and will allow individuals who opt for these higher deductible marketplace plans to pair their coverage with an HSA and take advantage of the tax and savings benefits.

Additionally, the legislation expands the definition of a qualified medical expense to include Direct Primary Care (DPC) arrangements. DPCs are health care models where a patient pays a recurring (often annual or monthly) fee directly to a primary care physician to cover a broad range of primary care services, such as annual wellness exams and communication with the physician. The OBBBA passed by the Senate allows individuals to use HSA funds to cover DPC services as a qualified medical expense. There are exceptions for services that require general anesthesia, prescription drugs (except for vaccines) and laboratory services not typically administered in an ambulatory primary care setting. This change aligns with AMA policy.

While the legal limitation is clear under current law, any future policy change to allow unused premium tax credits to fund HSAs or similar accounts would need to be carefully designed to avoid exacerbating coverage disparities. Subsidy overages are more likely among individuals who are younger, healthier, or select lower-premium plans. Redirecting these funds could incentivize underinsurance or plan gaming, undermining the ACA's foundational principle that subsidies are tied to actual coverage purchases. Such an approach must be evaluated through an equity lens to ensure it does not disproportionately benefit those least in need of subsidization or erode access to comprehensive coverage for others.

PROPOSED CHANGES TO HSAs

Contributions from family members, employers, or other designated individuals, not limiting contributions to only those on HDHPs

According to the IRS ([Publication 969](#)) any eligible individual can contribute to an HSA. For an employee's HSA, the employee, employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed or unemployed individual, the individual can contribute to the account. Family members or any other person may also make contributions on behalf of an eligible individual.¹⁵

Contributions to the accounts of dependents, including children and spouses

There is no prohibition from contributing to a spouse's HSA if they are individually eligible and have an account of their own. As long as the annual limit has not been met, an individual can contribute to their spouse's HSA. There are no general prohibitions against someone else making a contribution on behalf of an eligible individual. However, dependent minor children generally cannot have their own HSAs as they are not individually eligible because they are dependents claimed on someone else's tax return.

Contributions from Medicare and Medicaid enrollees

The proposal to allow contributions from individuals enrolled in Medicare would require a change to Section 223 of the United States tax code. Under [26 U.S.C. § 223\(c\)\(1\)\(A\)\(ii\)](#), individuals are ineligible to contribute to an HSA if they are enrolled in any part of Medicare. IRS guidance ([Notice 2004-50, Q&A](#)) further clarifies that enrollment in Part A alone disqualifies an individual, even if they are otherwise covered by a HDHP. Under current law, once seniors become eligible for Medicare, they are no longer able to make deposits into HSAs since these funds can be used to pay Medicare premiums. Allowing contributions would mean decoupling HSA eligibility from HDHP enrollment. If seniors could make tax-deductible contributions to an HSA and then use those funds to pay for Medicare premiums, it would essentially allow retirees to deduct their Medicare premiums from their taxes. At this time, Congress has been unwilling to provide this benefit to Medicare enrollees, although it has been suggested.¹⁶

In 2023, Congress considered H.R. 5687, HSA Modernization Act of 2023. Under this proposal, it was assumed that people enrolled in HDHPs would no longer lose the tax preference for HSA contributions when they enroll in Medicare at age 65. As a result, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) expected that some beneficiaries who under current law would have dropped their HDHP coverage would instead have retained that coverage and make Medicare their secondary payer. At that time of consideration of this proposal, CBO and JCT estimated that allowing Medicare enrollees to contribute to HSAs would reduce revenues by \$8.5 billion and cause Medicare overlays to decline an additional \$2.7 billion over the next decade (2024-2033).¹⁷

More recently, in the House-passed version of H.R. 1, text included a change to allow people who are 65 or older and enrolled in Medicare Part A only to contribute to an individual HSA. If that individual is eligible to continue to contribute to an HSA, they may not use distributions to pay for health insurance and funds not used for qualified medical expenses would be subject to an additional 20 percent tax.¹⁸ Because the provision to allow HSA contributions from Medicare enrollees was not included in the final version of the OBBBA, it was not specifically assigned an updated score by CBO and JCT.

Medicaid enrollees typically do not have access to qualifying HDHPs. According to [Medicaid.gov](#), Michigan, Indiana, and Arkansas have used Section 1115 demonstration waivers to implement programs to offer HSAs for Medicaid beneficiaries. Iowa and Pennsylvania are also exploring the possibilities of using Medicaid funds to enroll

beneficiaries in these plans. States that have tried these programs have ended them after their trial periods due to low enrollment, cost, and additional administrative burdens.

Payment of health, dental, and vision insurance premiums from HSAs

Currently, health insurance premiums are not HSA-eligible expenses ([26 U.S.C. § 223\(d\)\(2\)\(B\)](#)), with the exception of Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance coverage and Medicare premiums, as well as some long-term care coverage premiums. For long-term care coverage, the amount of money that can be withdrawn tax free to cover these premiums depends on age. The older the individual, the more money that is able to be deducted to cover these costs. Unemployed individuals may qualify to withdraw funds from their HSA to cover health insurance premiums, but only if they are receiving federal or state unemployment benefits or are covered by COBRA. Allowing payment of health, dental, and vision insurance premiums from an HSA would require a statutory change but is something that has been proposed in past legislation on expanding HSAs.

Directing some or all of the money spent by an employer on health insurance into an employee HSA

Under [26 U.S.C. § 106\(d\)\(1\)](#) employers can contribute to employees' HSAs with contributions generally excluded from employee gross income and not subject to federal income tax, Social Security, Medicare, or federal unemployment tax. For 2025, the HSA contribution limits are \$4,300 for individual coverage and \$8,550 for family coverage. Employers can make direct contributions or matching contributions, similar to retirement accounts. Employers can also make contributions tied to organizational wellness incentives and goals. Individual contribution limits must be adjusted based on employer contributions to ensure the total contribution cap is not exceeded.¹⁹

Permit the transfer of funds between HSAs, including between spouses and family members

According to current tax law ([26 U.S.C. § 35](#) and [26 U.S.C. § 223\(b\)\(5\)](#)), each eligible individual must open and own their own HSA. The account belongs to that individual and cannot be transferred unless the asset is divided during a divorce or if the account holder dies. There are specific rules laid out in each of the following scenarios, based on who is eligible for the account:

- **Family HDHP Coverage – Both Spouses are Eligible:** If one or both spouses have family HDHP coverage, the spouses may divide one maximum contribution amount for family coverage between their accounts, however they choose.
- **Self-Only HDHP Coverage – Both Spouses are Eligible:** If each spouse has self-only HDHP coverage, each is eligible to contribute up to the amount allowed for self-only coverage.
- **Family HDHP Coverage – One Spouse is Eligible:** The HSA account is owned by the eligible individual who can contribute up to the annual family contribution limit.
- **Family HDHP Coverage – One or Both Spouses and Non-dependent Child are Eligible:** An individual who is eligible to be claimed as a dependent on another individual's tax return is not eligible to open their own HSA. However, the ACA requires health plans to provide coverage to children until they reach age 26, even if the adult child is not eligible to be claimed as a dependent on the parent's income tax return. In this instance, the non-dependent child who is covered by their parents' family HDHP would be eligible to open their own HSA.
- **Family HDHP Coverage and Single HDHP Coverage – Both Spouses are Eligible:** If one spouse has family HDHP coverage and the other spouse has self-only HDHP coverage, the spouse with the self-only coverage may contribute up to the limit allowed for individual contribution. The spouse with the family HDHP coverage must reduce their contribution amount by the contribution amount made by the spouse with self-only coverage. The spouses' combined contribution amounts cannot exceed the amount allowed for family coverage.²⁰

Care for dependent children would be paid out of the parents' account(s) and the total amount of money contributed could not exceed the cap for family coverage. Transfers between spouses and other family members are currently restricted, but spouses can inherit the HSA when the owner dies if the living spouse has been named a beneficiary to the account. In the case of divorce, an HSA is treated like any other asset and division of the asset is open to negotiation. Movement of all or part of an HSA to a former spouse as required by divorce decree is not a taxable transfer as long as the account remains an HSA. If the money is moved to a different type of account the money will be taxed at 20 percent. Notably, an HSA cannot be used to pay medical expenses for an ex-spouse tax-free, even if

the court orders the ex-spouse to remain on the family insurance plan for a specific period following the divorce. If money is withdrawn to pay for the medical expenses of an ex-spouse, the money will be taxed at 20 percent. If there are children involved, either spouse can use money from the HSA to pay for a child's medical expenses, regardless of which parent claims the child as a dependent.

The tax code would need to be modified and careful guardrails would need to be established to accomplish this proposed change. There would also likely be pushback on efforts to more freely transfer funds tied to concerns about tax sheltering.

Expansion of the role and functions of HSAs

HSAs can be beneficial to some individuals but should not be considered a one size fits all approach, nor should they replace all other types of health insurance. The AMA supports patient freedom of choice when choosing a health plan and supports HDHPs paired with HSAs as one option for individuals to consider when making this decision.

Placing unused Affordable Care Act (ACA) premium tax credits in HSAs

Under current law, when an individual does not use their entire allotted ACA premium tax credit the unused, leftover premium tax credit goes away and the individual loses part of the benefit of the tax credit. For example, if an individual qualifies for a premium tax credit to cover a silver plan but instead chooses to enroll in a bronze plan where the premium is lower, the leftover premium tax credit disappears. If an individual is at 150 percent of the federal poverty level (FPL), is not eligible for Medicaid, and is enrolling in an ACA Marketplace plan, they would qualify for \$4,662 per year of premium tax credits for a silver plan. However, if that individual instead chose to enroll in a bronze plan, they would receive \$3,580 per year in premium tax credits, essentially leaving \$1,082 of benefits on the table per year. This example was calculated using the [KFF Health Insurance Marketplace Calculator](#) for 2025 plans.

Furthermore, the OBBBA has changed the process for excess ACA premium tax credits. This scenario is slightly different than the one outlined above; however, prior to passage of the OBBBA, if an enrollee received excess premium tax credits because their estimated income was lower than their actual income, they had to repay the excess. For most enrollees there was a repayment cap based on household income and for those with a household income over 400 percent of the federal poverty level (FPL), there was no limit and the entirety of the excess tax credit had to be repaid. An individual with an income less than 200 percent FPL had a cap of \$375 and families with a household income between 300 – 400 percent FPL had a cap of \$3,150. Following the passage of the OBBBA, beginning on January 1, 2026, all premium tax credit recipients must repay the full amount of excess, no matter their household income.²¹

Given both of these scenarios, it would be valuable for the AMA to support tax credits that are designed to allow individuals to contribute to an HSA through the application of unused or residual credit amounts. Doing so could encourage individuals to be proactive about saving for future health care needs and could potentially reduce medical debt in the face of unexpected medical expenses.

AMA POLICY

AMA has several policies that either directly or indirectly relate to the points raised by Resolution 803-I-24 and/or portions of the OBBBA passed into law.

Regarding contributions to HSAs from Medicare and Medicaid enrollees, [Policy H-290.972](#) outlines principles for states to consider when deciding if they are going to offer HSA programs to Medicaid beneficiaries. These guidelines include, amongst other standards, making beneficiary participation voluntary, providing first-dollar coverage for preventive care, allowing payments to non-Medicaid providers by beneficiaries to count towards deductibles and out-of-pocket spending limits, and prohibiting the use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private health insurance, including the employee share of the premium for employer-sponsored coverage.

[Policy H-165.852\(7\)](#) states that legislation promoting the establishment of and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and

coverage and freedom of choice in health insurance. The addition of dental and vision premiums as qualified medical expenses could be considered within this policy.

The AMA has policy on how HSAs fit into the larger health insurance landscape. [Policy H-165.852\(3\)](#) states that advocacy of HSAs continues to be incorporated prominently in AMA's campaign for health insurance market reform, indicating the organization's commitment to improving HSAs and [Policy H-165.833](#) states that as part of the AMA's organizational goal of amending and improving the ACA, the AMA will advocate to expand the use of HSAs and a means to provide health insurance.

[Policy H-165.828](#) states that the AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy and supports clear labeling of exchange plans that are eligible to be paired with an HSA with information on how to set up an HSA. Additionally, [Policy H-165.865](#) states that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures.

[Policy D-165.954](#) states that the AMA will monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

[Policy D-165.962](#) states that the AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.

[Policy H-165.863](#) states that along with efforts to liberalize the Health Savings Account rules, the AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.

[Policy H-385.912](#) is addressed in the final language of the OBBBA and states that it is AMA policy that the use of an HSA to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense. Furthermore, the policy states that the AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for DPC and to enter DPC periodic-fee agreements without IRS interference or penalty.

DISCUSSION

With appropriate guardrails in place, expanded use of HSAs can allow for more flexibility for consumers' medical spending. The recommendations from the Council improve usability and flexibility for those who have HSAs, but are not intended to encourage or incentivize replacing other forms of health coverage with these accounts. Notably, many of the changes proposed in Resolution 803-I-24 and the Council's corresponding recommendations would require changes to U.S. tax code and would potentially come with a hefty price tag.

The tax code currently allows family members and/or others to contribute to an individual's HSA, as long as the total amount does not exceed the annual contribution limit. This allows an individual to receive financial support from their community in the event of a medical emergency. Similarly, an individual can contribute to the accounts of their spouse or children if they have their own individually eligible HDHP paired with an HSA.

The Council believes it is reasonable to support continued contributions to an HSA once an individual has reached 65 years of age and is eligible for Medicare. Many individuals live decades past eligibility for Medicare, and allowing continued contributions to an HSA can help those individuals continue to prepare for the medical costs associated with aging, especially since funds from an HSA can be used to pay for long-term care premiums. However, in order to follow the current tax laws, guardrails would need to be in place to ensure this benefit does not further strain the Medicare program and can be accessed fairly among Medicare beneficiaries, regardless of socioeconomic status. The Council believes that further study from tax experts and others is warranted to develop the specific guardrails but

recommends that Medicare enrollees be allowed to continue to contribute to an HSA. Regarding Medicaid, the AMA has extensive policy outlining principles for states considering offering HSA-like accounts to their Medicaid populations. Notably, most states that have attempted to do so have ended these programs due to low use, expense, and/or associated administrative burdens.

Under [Policy H-165.852](#), the AMA supports the use of HSA funds to pay for health and long-term care insurance premiums. The Council believes it is appropriate to expand this to include the payment of dental, vision, and hearing premiums as well. This strengthens AMA policy and can provide additional benefits to those with HSAs.

The proposed policy in Resolution 803-I-24 addressing employer contributions is not clear and the Council has chosen not to include a recommendation regarding employer contributions to HSAs. Currently, employers are able to contribute to employees' HSAs and many choose to do so as a benefit of employment.

The Council appreciates the intent of transferring HSA funds between spouses and family members but believes there needs to be additional study on the feasibility and tax implications. This change would make an HSA akin to a 529 account used for educational purposes; however, the two are treated differently in U.S. tax code. An external study and/or demonstration project could be done to examine the intricacies and implications of making such a change. For example, this study could explore supporting narrowly tailored exceptions allowing spousal transfers during joint filing years or transfers to legally dependent children for qualified expenses while opposing broader unrestricted portability that risks gaming the tax system.

Long-standing AMA policy supports freedom of choice when it comes to health insurance for patients and the Council believes expanded use of HSAs allows for more freedom and flexibility for individuals who wish to utilize these accounts. However, expanded use of HSAs should be complementary to health insurance and not be used as a replacement.

The Council discussed the referred amendment and agrees that placing unused ACA premium tax credits into an HSA when a plan's premium is lower than the tax credit would help strengthen ACA benefits. The Council notes that the feasibility of this may be limited at this time, especially with the provision in the OBBBA stating that unused premium tax credits will be paid back to the government regardless of income and the expiration of enhanced premium tax credit program by the end of 2025.

Finally, the OBBBA included provisions strengthening HSAs that warrant corresponding AMA policy. The Council supports allowing those who enroll in high-deductible bronze plans to contribute to an HSA. [Policy H-165.828](#) encourages the development of demonstration projects to test this concept. The Council believes continued demonstration projects already included in the policy are necessary and thus recommends updating the policy with a new clause that aligns with the federal policy change. The Council also believes that silver plans should also be considered HSA-eligible HDHPs to prevent incentivizing people to enroll in bronze plans, which often offer less coverage and have higher out-of-pocket costs. Second, the OBBBA changes the law to allow HSA funds to pay for DPC services. [Policy H-385.912](#) states that the use of an HSA to access DPC providers and/or receive care from a DPC medical home constitutes a bona fide medical expense. Therefore, the Council recommends that Policy H-385.912 be reaffirmed. Additional text included in the House-passed version of the bill looked to significantly expand the use of HSAs and could be informative as to where Congress and the Trump Administration could potentially be open to exploring additional changes.

In considering these proposals, the AMA's guiding framework remains rooted in promoting access to high-quality, affordable coverage; minimizing administrative complexity; and avoiding regressive tax policies. Any HSA reforms must be consistent with these principles and should avoid subsidizing underinsurance or exacerbating inequalities.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 803-I-24 and the remainder of the report be filed:

- 1) That our American Medical Association (AMA) support permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner

of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded.

- 2) That our AMA support contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees.
- 3) That our AMA amend Policy H-165.852 by addition to read as follows:

HEALTH SAVINGS ACCOUNTS, H-165.852(7)

(7) legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

- 4) That our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members.
- 5) That our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts.
- 6) That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

(3) Our AMA (i) encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and (ii) supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer undue financial hardship.

- 7) That our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies.
- 8) Our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits.
- 9) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid Program, which outlines several principles for states considering offering beneficiaries HSAs.
- 10) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and Affordable Care Act, which states that as part of the AMA's organizational goal of amending and improving the Affordable Care Act, the AMA will advocate to expand the use of HSAs as a means to provide health insurance.
- 11) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that the use of a health savings account to access direct primary care (DPC) providers and/or to receive care from a direct primary care medical home constitutes and bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for DPC and DPC medical home models as a qualified medical expense. Furthermore, H-385.912 states that the AMA will seek federal legislation or regulation to amend appropriate sections of the IRS code to specify that DPC access or DPC medical homes are not health "plans" and that the use of HSA funds to pay for DPC provider services in such setting constitutes a qualified medical expense, enabling patients to use HSAs to help pay for DPC and to enter DPC periodic-fee agreements without IRS interference or penalty.

[Editor's note: The following adopted language was referred]

- 12) Our AMA advocates for using the expanded Affordable Care Act premium tax credits as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts or other cash savings accounts.

Fiscal Note: Minimal

REFERENCES

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- ² CMS.gov. What is a Health Savings Account? <https://www.cms.gov/marketplace/outreach-and-education/health-savings-account.pdf>
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**Council on Medical Service Report 1-I-25
Health Savings Account Reform
Policy Appendix**

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, D-165.954

Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with Health Savings Accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

(CMS Rep. 3, I-05; Modified: CMS Rep. 1, A-15)

Health Savings Accounts for Older Americans, D-165.962

Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.

(Sub. Res. 702, A-04; Reaffirmation: A-10; Reaffirmed: BOT Rep. 04, A-20)

Flexible Spending Accounts (FSAs), H-165.863

1. Along with other efforts to liberalize Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.

2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending Accounts.

(Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmation: A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 5, and 7, I-99; Appended by Res. 220, A-00; Reaffirmation: I-00; Res. 120, A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation: A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation: I-03; Reaffirmation: A-04; Consolidated: CMS Rep. 7, I-05; Appended: Res. 121, A-15; Modified: CMS Rep. 1, A-15)

Health Savings Accounts, H-165.852

It is the policy of the AMA that:

- (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
- (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
- (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
- (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
- (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
- (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs;
- (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

(CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation: A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation: I-00; Reaffirmed Res. 109 & Reaffirmation: A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation: A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation: I-03; CMS Rep. 6, A-04; Reaffirmation: A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation: A-07; Reaffirmation: A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 5, A-18)

Health Savings Accounts in the Medicaid Program, H-290.972

It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:

- A. Make beneficiary participation voluntary;
- B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
- C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
- D. Set deductibles at 100% of account contributions, but no higher;
- E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
- F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
- G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
- H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online) and in multiple languages;

- I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
 - J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
 - K. Monitor the impact on utilization and beneficiary financial burden;
 - L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
 - M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.
- (CMS Rep. 1, I-06; Modified: CMS Rep. 01, A-16; Reaffirmation: A-18)

Increasing Accessibility to Incontinence Products, H-155.955

Our AMA supports increased access to incontinence products for children and adults, including the removal of sales tax, and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs).
(Res. 908, I-18; Modified: Res. 231, A-22)

Health Insurance Affordability, H-165.828

1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
 8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
- (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701 I-21; Reaffirmed: Res. 826, I-24)

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, H-165.849

1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering case discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
 2. Our AMA will engage in a dialogue with health plan representatives (e.g., Americas Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.
- (CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15; Appended: BOT Action in response to referred for decision Res. 805, I-16; Reaffirmed: CMS Rep. 09, A-19)

Transparency of Employer Sponsored Health Insurance, H-155.961

Our AMA encourages employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits

paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts.

(Res. 127, A-07; Reaffirmed: CMS 01, A-17)

Direct Primary Care, H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.

2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.

3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

(Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res 102, A-19)

Principles for Structuring a Health Insurance Tax Credit, H-165.865

(1) AMA support for replacement of the present exclusion from employees’ taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of the tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.

(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.

(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.

(CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation, I-00; Reaffirmation: A-02; Reaffirmation: I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation: A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation: A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation: A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

Aligning Clinical and Financial Incentives for High-Value Care, D-185.979

1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that

a. medical services may differ in the amount of health produced.

b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.

2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.

3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
 4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
 5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
 6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
 7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that:
 - a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
 - b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
 8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.
- (Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 2, I-20; Reaffirmation: A-22)

Amend the Patient Protection and Affordable Care Act (PPACA), H-165.833

1. Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the patient-physician relationship. These needed changes include but are not limited to:
 - repeal of the Independent Payment Advisory Board (IPAB);
 - study of the Medicare Cost/Quality Index;
 - repeal of the non-physician provider non-discrimination provision;
 - enactment of comprehensive medical liability reform;
 - enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program;
 - enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and
 - expanding the use of health savings accounts as a means to provide health insurance coverage.
 2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA policy.
- (Res. 217, A-11; Reaffirmation: A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of Res. 215, A-15; Reaffirmed: Res. 206, A-19)

2. TELEHEALTH LICENSURE

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies D-480.960, D-480.964 and H-48.969

Telehealth falls within the Council on Medical Service's purview and has been the subject of several reports, including two addressing state licensure requirements and exceptions allowing physicians to provide telehealth across state lines:

- [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth, was written during the COVID-19 pandemic, when telehealth use increased dramatically. This report established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to an existing patient, provided that a previous in-person visit has occurred and the telehealth services are incident to an ongoing care plan or one that is being modified ([Policy D-480.960](#)). Prior to this policy being adopted, the AMA had supported narrow exceptions to state licensure requirements for physician-to-physician consultations and in the event of an urgent or emergent circumstance ([Policy H-480.969](#)).

- [Council on Medical Service Report 1-I-19](#), Established Patient Relationships and Telemedicine, was written prior to the pandemic at a time when fewer physicians were practicing interstate telehealth. This report established new AMA policy encouraging participation in the Interstate Medical Licensure Compact (ILMC) and supporting state efforts to expand licensure recognition across state lines ([Policy D-480.964](#)).

This report was self-initiated by the Council to assess the need for additional AMA policy on licensure exceptions that permit physicians to use telehealth to provide care to patients in other states without seeking licensure in the state where the patient is located. As such, this report provides updates on interstate telehealth, including state policies and updated model policies; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

As highlighted in [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth, the use of telehealth by physicians and other health providers rapidly expanded during the COVID-19 pandemic, enabling physicians to provide uninterrupted continuity of care while protecting patients and physicians from exposure to the virus. Whereas telehealth encounters made up a small percentage of total care visits before the pandemic, they increased by 2,000 percent during the first six months of the public health emergency.¹ Of note, telehealth use continues at significantly higher rates than pre-pandemic, as data from the AMA's Physician Practice Benchmark Surveys (nationally representative surveys of non-federal physicians providing at least 20 hours of patient care per week) demonstrates. According to data from Benchmark Surveys fielded between 2018 and 2024, only about one-quarter of physicians were in a practice that used any form of telehealth in 2018, a figure that rose to 79 percent in 2020 before decreasing to 71 percent in 2024.² To support this transformation, telehealth became a core element of the AMA Recovery Plan for America's Physicians post pandemic.

The increased availability of telehealth has mitigated some of the barriers patients face in accessing essential health care services, especially in rural and underserved areas where physician specialists may not be available close to home and patients must travel long distances for in-person care. The expanded telehealth landscape has also produced innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of care modalities. Such models reduce fragmentation of care and fortify physician-patient relationships because patients receive telehealth services from their regular physicians, as opposed to payer-facilitated telehealth programs or corporate telehealth-only entities. Rapid growth in the use of telehealth, including by large telehealth-only companies, has challenged policymakers and regulators to facilitate the expanded and appropriate use of telehealth technologies while ensuring care coordination and quality.

INTERSTATE TELEHEALTH

As explained in [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth, and [Council on Medical Service Report 1-I-19](#), Established Patient Relationships and Telemedicine, medical licensure is granted to physicians by state medical boards, a structure that dates to the 1800s and is embedded in state authority granted by the [10th amendment](#). The prevailing standard of care in this country affirms that the practice of medicine occurs where the patient is located and, therefore, that physicians are generally required to be licensed in the state where the patient is located. This standard also applies to telehealth, which is considered to be provided at the location of the patient and, therefore, typically requires licensure in the patient's state. This standard enables states to make sure that all types of health care providers adhere to that state's laws and regulations (e.g., licensing requirements and scope of practice parameters) and that the public is protected from the unprofessional and improper practice of medicine. Alternatives to state-based licensure raise accountability and enforcement concerns as states do not have interstate policing authority and cannot investigate crimes that happen in another state.

When the public health emergency was declared in March 2020, the rapid proliferation of federal and state temporary waivers of telehealth coverage and payment regulations facilitated a large-scale expansion of telehealth that helped meet the high demand for virtual care. Most states also waived certain licensure requirements, enabling physicians and other health providers to work across state lines without having to be fully licensed to treat patients in those states. Some states issued broad reciprocity waivers while others required registration with, or approval by, the state medical board in order to practice in that state. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to existing patients in that state, or by physicians in contiguous states who had established relationships with state residents.

During the pandemic, people living near state borders, patients in need of specialized care in another state, and more mobile patients such as college students were more likely to receive interstate telehealth visits.³ Additionally, individuals were able to participate remotely in clinical trials overseen by the Food and Drug Administration.⁴ Most temporary COVID-19-related licensure flexibilities have since been lifted; however, many stakeholders—including the AMA—support continued flexibility to provide cross-state telehealth in reasonable circumstances that would be beneficial to patients and physician-patient relationships.

Interstate Medical Licensure Compact

Relatedly, the AMA has long recognized the costs and burdens associated with obtaining physician licenses to practice medicine (or telehealth) in multiple states and has supported solutions that streamline licensure processes while preserving state oversight of the care of patients within their borders. The [Interstate Medical Licensure Compact \(IMLC\)](#) is considered one such solution because it provides an expedited pathway to licensure for qualifying physicians seeking to practice in multiple states. The mission of the Compact is to increase access to health care, particularly for patients in underserved or rural areas, by making it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of telehealth.⁵ Because the IMLC adopts the prevailing standard that the practice of medicine occurs where the patient is located at the time of the visit, physicians practicing under a license facilitated by the Compact must comply with the statutes, rules, and regulations of each state wherein they choose to practice. Of note, the reach of the IMLC has grown significantly since the Council began studying telehealth policy and, at the time this report was written, 42 states—plus the District of Columbia (DC) and Guam—were member jurisdictions.⁶ Since operations began in April 2017, over 150,000 licenses have been issued through the IMLC process, helping over 42,000 physicians.⁷

Federal/National Initiatives

Although physician licensure is regulated by states, a handful of federal initiatives have facilitated cross-state telehealth in certain circumstances. Physicians and other professionals employed by the U.S. Department of Veterans Affairs, Indian Health Service, and Department of Defense are generally permitted to practice medicine—including via telehealth—outside of the state where they are licensed. Of note, these health systems are federally funded and regulated and serve limited patient populations. Health care teams (including physicians) mobilized by the National Disaster Medical System, which is a partnership of the U.S. Departments of Health and Human Services, Homeland Security, Defense, and Veterans Affairs, essentially become federal employees while responding to disasters and emergencies, and physicians are thus able to temporarily practice in another state as part of that team without seeking a new license.

The [Uniform Telehealth Act](#), proposed by the Uniform Law Commission in 2022, authorizes the establishment of a state registration system for practitioners licensed in other states that allows registrants to provide telehealth services in states adopting the Act. The model bill, enacted by Washington State and DC, also permits out-of-state practitioners to provide telehealth care: 1) in consultation with other practitioners licensed in the state; 2) to provide specialty assessments, diagnoses, and/or recommendations for treatment to a patient located in the state; and 3) to existing patients with whom a practitioner has an established practitioner-patient relationship. The [Uniform Emergency Volunteer Health Practitioners Act](#) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the DC that have enacted the model Act.

State Exceptions to Licensure Requirements

Because the standards and scope of telehealth services should be consistent with related in-person care (consistent with [Policy H-480.946](#)), state licensure requirements vary by but still generally adhere to the prevailing standards, with some exceptions. In an attempt to address some of the challenges to practicing telehealth across state lines, states have adopted a variety of measures, including limited licensure exceptions for certain types of care, alternative licensure/registration processes for interstate telehealth, and cross-state licensing that allows physicians to practice in contiguous states. An example of the latter is the agreement between DC, Maryland, and Virginia medical boards that facilitated expedited licensure reciprocity for physicians practicing in the area.⁸

According to the Federation of State Medical Boards (FSMB), all state medical boards require that physicians engaging in telehealth be licensed in the state where the patient is located or registered in the state if the state maintains

a special registry for interstate telehealth. Licensure exceptions and/or consultation exceptions for telehealth services rendered across state lines are in place in 40 states plus DC and Guam.⁹ To qualify for an exception, physicians must have an existing license to practice medicine in good standing. State-based licensure exceptions can be useful to physicians because they permit limited interstate telehealth work without requiring lengthy applications or licensure fees. Some of the more common state licensure exceptions include:

- *Exceptions allowing episodic and follow-up care* via interstate telehealth, which are available in 14 states and DC.¹⁰ For example, Alaska permits physicians licensed in other states to provide telehealth services for ongoing treatment or follow-up care, as long as there is an established physician-patient relationship and the physician has previously conducted an in-person visit with the patient.¹¹ Ohio's licensure exception allows an out-of-state physician or surgeon, who treated the patient out of state, to provide follow-up services within one year.¹²
- *Exceptions allowing a limited number of telehealth encounters* from out-of-state physicians. For example, Alabama permits services provided on an irregular or infrequent basis, defined as occurring less than 10 days in a calendar year or involving fewer than 10 patients in a calendar year.¹³ Minnesota similarly permits the practice of interstate telehealth as long as services are provided on an irregular (less than once a month) or infrequent (fewer than 10 patients per year) basis.¹⁴
- *Exceptions allowing licensed out-of-state physicians to consult* with in-state licensed physicians, provide second opinions, or provide care in an emergency or disaster, which are permitted in more than 30 states.
- *Exceptions allowing certain mental or behavioral health providers licensed or registered in another state to provide telehealth services* to in-state residents, such as those in place in Colorado and Utah.
- Some states have *universal licensure recognition laws* which allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.

According to FSMB, eight states either allow interstate telehealth if physicians register with the state medical board and pay associated fees, or have a waiver in place that allows the practice.¹⁵ Most of these states impose additional requirements, including Florida which requires out-of-state physicians to designate a duly appointed registered agent in the state. Some states also limit the types of services that can be provided by registered out-of-state providers, such as for mental and behavioral health (e.g., Utah) or consultation services (Maine). Many states with registration processes in place prohibit out-of-state physicians who register with the state medical board from opening offices in the state.¹⁶

Another approach taken by eight states involves the issuance of a telehealth-specific license or certification.¹⁷ Tennessee's telehealth certification is limited to osteopathic practice. As previously noted, DC, Maryland, and Virginia have entered into a regional compact recognizing licensure reciprocity across these jurisdictions. Pennsylvania also issues extraterritorial licenses that allow physicians in adjoining states, whose practices extend into Pennsylvania, to practice in the state provided other requirements are met and the adjoining state maintains similar privileges.¹⁸

Of note, most telehealth registration processes and telehealth-only licenses require out-of-state physicians to submit paperwork and fees before they are able to practice interstate telehealth, even on a limited basis. Depending on the time and money required, these processes may or may not be worth pursuing. Although the fees for telehealth registrations and licenses vary by state, most cost less than the IMLC, which requires an initial \$700 fee plus the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.¹⁹ If a physician wishes to practice in multiple states, any such fees may be beyond the budgets of many physician practices—particularly independent practices.

Importantly, compliance with state licensure and medical practice requirements does not guarantee that insurers will cover a telehealth visit with a patient in another state. Although Medicare generally requires out-of-state providers to comply with state laws, other payer policies vary and therefore it is important that physicians review specific payer policies before providing telehealth services to patients in another state. Liability concerns are also integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MODEL POLICY

Around the time [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth, was being written, FSMB—the national organization representing and supporting state medical and osteopathic boards—convened a special workgroup charged with updating its model policy in light of the proliferation of telehealth during the pandemic. Representatives from several state medical boards, the American Telemedicine Association, and the AMA participated in the FSMB workgroup, during which the AMA was able to facilitate the inclusion of language consistent with AMA telemedicine/telehealth policy. In April 2022, the FSMB House of Delegates adopted the workgroup’s final report which, consistent with AMA policy, affirms that:

- A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located.
- The practice of medicine occurs where the patient is located at the time the telehealth technologies are used.
- Physicians who diagnose, treat, or prescribe using online service sites are engaged in the practice of medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.²⁰

[FSMB’s updated model policy](#) permits the practice of interstate telehealth, without the need for licensure in the state where the patient is located, for the following:

- *Physician-to-physician consultations*, which permit physicians licensed in another state to consult with licensed practitioners responsible for diagnosing and treating a patient in the patient’s state. [Policy H-480.969](#) similarly supports an exception for physician-to-physician consultations.
- *Prospective patient screening for complex referrals*, which exempts physicians providing specialty assessments or consultations, such as at centers for excellence, from obtaining licenses in the state where the patient is located in order to screen a patient for acceptance of a referral. FSMB policy specifies that, “If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located.” [Policy H-480.969](#) supports an exception for physician-to-physician consultations but does not specifically address prospective patient screening for complex referrals.
- *Episodic follow-up care for established patients*, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. Policies [D-480.960](#) and [H-480.969](#) similarly support a continuity of care exception.
- *Follow-up after travel for surgical/medical treatment*, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, “Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary.” Policies [D-480.960](#) and [H-480.969](#) support continuity of care exceptions that are inclusive of follow-up care.
- *Clinical trials*, so that physicians working on clinical trials enabled by telehealth are not precluded from including patients residing in states where the physician is not licensed. FSMB policy stipulates that, “Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary.” A licensure exception for clinical trials work is not addressed in AMA policy.

A comparison of telehealth licensure exceptions in FSMB policy and AMA policy can be found in Appendix A of this report. Of note, FSMB’s model policy includes two exceptions that are not specifically addressed in AMA policy—for clinical trials work, and for prospective patient screening for complex referrals. A clinical trials exception alleviates state licensing barriers that prevent physicians from recruiting patients from outside of the state, potentially increasing trial participation and accessibility.

An exception allowing prospective patient screening for complex referrals recognizes the geographic barriers many patients face in seeking specialty assessments that are not available close to home. Although this exception is limited to screenings for referral, the National Organization for Rare Disorders advocates for a broader expansion of interstate telehealth pathways for rare disease patients, acknowledging that for many rare diseases there are only a handful of specialists nationwide.^{21,22}

Preliminary discussions among physicians and other stakeholders, including the AMA, have also begun to explore the potential for a national registry that would allow out-of-state physicians to use telehealth to treat patients enrolled in clinical trials, patients being screened for complex referrals, and new patients with rare and/or life-threatening conditions without obtaining a license in the patient's state. This concept is in the early stages of development and, therefore, its feasibility is unclear.

AMA POLICY

The AMA has numerous telemedicine/telehealth policies as well as model state legislation. [Policy D-480.960](#) was established by [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth, along with a follow-up Board of Trustees Management Report. This policy directs the AMA to work with FSMB, state medical associations, and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

- a. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action;
- b. There is a pre-existing and ongoing physician-patient relationship;
- c. The physician has had an in-person visit(s) with the patient;
- d. The telehealth services are incident to an existing care plan or one that is being modified;
- e. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements; and
- f. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

A key safeguard included in [Policy H-480.946](#), which was established through [Council on Medical Service Report 7-A-14](#), Coverage and Payment for Telemedicine, stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. Additional longstanding AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods ([Policy H-480.969](#)). This policy also delineates exemptions from such licensure requirements for physician-to-physician consultations and in the event of emergent or urgent circumstances, and also allowances—by exemption or other means—for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan (the latter clause was added via [Council on Medical Service Report 8-Jun-21](#), Licensure and Telehealth).

[Policy D-275.994](#) supports the IMLC. Under [Policy D-480.964](#), which was established via [Council on Medical Service Report 1-I-19](#), Established Patient Relationships and Telemedicine, the AMA will work with state medical associations to encourage states to consider joining the IMLC; advocate for reduced application and licensure fees processed through the IMLC; work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services; and support state efforts to expand physician licensure recognition across state lines in accordance with the standards outlined in [Policy H-480.946](#).

[Policy D-480.999](#) opposes a single national federalized system of medical licensure. [Policy H-480.974](#) states that our AMA will work with FSMB, and state and territorial licensing boards, to develop licensure guidelines for telemedicine/telehealth practiced across state boundaries. [Policy D-480.969](#) states that our AMA will work with FSMB to draft model state legislation to ensure telemedicine/telehealth is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policies [H-275.978](#) and [H-275.955](#) urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. [Policy D-480.963](#) directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

[Policy H-130.941](#) supports the Uniform Emergency Volunteer Health Practitioners Act. Code of Medical Ethics [Opinion 1.2.12](#) states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty

societies and adhere to applicable law governing the practice of telemedicine. Clinical trials are addressed by numerous policies, including Policies [H-460.911](#), [H-460.912](#), and [H-460.965](#), and Code of Medical Ethics [Opinion 7.1.4](#). The AMA has substantial scope of practice policy, including Policies [D-160.995](#), [H-270.958](#), and [H-160.949](#). Principles for the supervision of nonphysician providers when telemedicine is used are outlined in [Policy H-160.937](#).

DISCUSSION

Previous House of Delegates discussions of Council on Medical Service reports on this topic were robust and reflective of the range of physician opinions about appropriate licensure flexibilities that allow telehealth services to be provided across state lines. Consistent with previous work, the Council adopted a balanced approach to policy development that seeks solutions for physicians and patients as well as appropriate guardrails that ensure high quality patient care. The Council continues to believe that there must be clear lines of accountability in licensure to protect patients, and that licensure of physicians and other health professionals should remain within the purview of each state. At the same time, we recognize that AMA policy must keep pace with telehealth innovations that mitigate geographic barriers and enable patients to access medical care that is not available close to home. In developing this report, the Council found that previous calls for national telehealth licensure, which AMA policy opposes ([Policy D-480.999](#)), have lessened somewhat, in part because of ongoing concerns about safety and the preservation of states' rights but also in response to increasingly divergent state policies on reproductive health, gender-affirming care, and other health policy issues.²³

AMA policy already supports streamlining licensure processes and reducing associated costs for physicians; use of the IMLC; state efforts to expand licensure recognition across state lines; interstate telehealth allowances for continuity of care purposes; and additional exemptions for physician-to-physician consultations and in the event of urgent or emergent circumstances. We continue to believe that exceptions allowing cross-state telehealth in common-sense circumstances remain an important pathway for patients and physicians. After reviewing the literature and updated model policies released since the Council's 2021 report, we believe that exceptions are warranted for both physicians using telehealth to prospectively screen patients for complex referrals, and physicians working on and recruiting patients for clinical trials. As with any exception, a physician must have a medical license in good standing in order to qualify. Accordingly, we recommend amending [Policy H-480.969\[1\]](#) to support an exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition. We believe this exemption will alleviate some of the obstacles patients face when seeking specialty assessments for complex and/or rare conditions. If, after the telehealth assessment, the physician agrees to diagnose or treat the out-of-state patient, the patient will need to travel to the physician for treatment. After establishing a treatment plan, incident care that is needed between in-person visits and is appropriate for telehealth may be provided under a continuity of care exception.

The Council also recommends amending [Policy H-480.969\[1\]](#) to support an exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial, as long as the trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy. Further, the Council recommends supporting an exemption for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that: 1) the trial meets certain standards; 2) assessments are not intended to replace care for the patient outside of the context of the trial; and 3) physicians identify a physician in the patient's state in case in-person care is needed. With recommended guardrails in place, we believe these exemptions will improve the accessibility of clinical trials and increase participation. Lastly, we recommend reaffirmation of Policies [D-480.960](#), which supports a licensure exceptions for continuity of care purposes, and [D-480.964](#), which supports the IMLC and expanded licensure recognition across state lines.

RECOMMENDATIONS

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

1. That our AMA amend Policy H-480.969[1] by addition to read:
 - (1) It is the policy of our American Medical Association (AMA) that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- a. Exemption from such a licensure requirement for physician-to-physician consultations.
 - b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient.
 - c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
 - d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition.
 - e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy, as selected by the referring physician and patient.
 - f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:
 1. The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;
 2. The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and
 3. Physicians planning to use telehealth identify a physician licensed in the patient's state to address in-person care needs that may arise from the clinical trial.
- eg. Application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
2. That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to existing patients if there is a pre-existing and ongoing physician-patient relationship and a previous in-person visit, and the care is incident to an existing care plan or one that is being modified.
 3. That our AMA reaffirm Policy D-480.964, which encourages states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact; advocates for reduced application and state licensure(s) fees processed through the IMLC; supports state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in AMA policy; and encourages states to pass legislation enhancing patient access to and proper regulation of telehealth services.

Fiscal Note: Minimal

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APPENDIX A

Telehealth Licensure Exceptions in Federation of State Medical Boards Policy and AMA Policy

Exceptions in FSMB Policy	Relevant AMA Policy
Physician-to-physician consultation , which permits a consulting physician licensed in another state to consult with a licensed practitioner who remains responsible for diagnosing and treating the patient in the patient's state.	Policy H-480.969 supports exemption of licensure requirements for physician-to-physician consultations.
Prospective patient screening for complex referrals , which exempts physicians providing specialty assessments or consultations, such as at	Policy H-480.969 supports exemption of physician-to-physician consultations but does not specifically

<p>centers for excellence. FSMB policy specifies that, "If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located."</p>	<p>address prospective patient screening for complex referrals.</p>
<p>Episodic follow-up care for established patients, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. FSMB policy specifies that, "If the patient is presenting with new medical conditions, the physician may consider directing the patient to receive local care," and "physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist ..."</p>	<p>Policy D-480.960 encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if:</p> <ol style="list-style-type: none"> The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action. There is a pre-existing and ongoing physician-patient relationship. The physician has had an in-person visit(s) with the patient. The telehealth services are incident to an existing care plan or one that is being modified. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. <p>Policy H-480.969 supports allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.</p>
<p>Follow-up after travel for surgical/medical treatment, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary."</p>	<p>Policies D-480.960 and H-480.969 support continuity of care exceptions but do not specifically address follow-up care after patients have traveled to another state for surgical or medical treatment.</p>
<p>Exceptions for clinical trials, which maintains that physicians working on clinical trials enabled by telehealth should not be precluded from including patients residing in states where the physician is not licensed. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary."</p>	<p>Not addressed in AMA policy.</p>

3. PAYMENT MODELS TO SUSTAIN RURAL HOSPITALS

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

*See Policies H-290.951, H-465.972, H-465.973, H-465.982, H-465.994,
H-465.997, D-465.998, and D-465.999*

At the 2025 Annual Meeting, the House of Delegates adopted [Policy D-465.994](#), which asked the American Medical Association (AMA) to:

Study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

Additionally, [Policy D-190.969\(2\)](#), adopted via [Council on Medical Service Report 6-I-23](#), Rural Hospital Payment Models, asks our AMA to:

Report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).

Considering both requests, this report provides an overview of the current state of rural hospitals and rural hospital payment and a review of piloted payment models. Additionally, this report reviews AMA policy and advocacy on the topic and offers recommendations in line with the aforementioned resolution and policy.

BACKGROUND

The approximately 20 percent of Americans who live in rural communities rely heavily on the nearest hospitals for many aspects of their health care.¹ This is especially important as those living in rural settings are more likely to be sicker, older, and underinsured than those living in more urban or suburban settings. For example, individuals living in rural America are more likely to have higher rates of heart disease, cancer, and stroke.² Additionally, those living in rural communities often must travel significant distances to access care. Estimates show that rural individuals, on average, drive nearly a full hour to obtain any kind of surgical care and two to three times longer to reach primary care than those in urban or suburban settings.^{3,4} This extended travel time is not only an inconvenience, but in some cases it can make accessing care very challenging, if not impossible, further exacerbating the existing health disparities that rural communities face.⁴ More detailed information on the state of rural health can be found in [Council on Medical Service Report 9-A-21](#), Addressing Payment and Delivery in Rural Hospitals, and [Council on Medical Service Report 9-A-23](#), Federally Qualified Health Centers and Rural Health Care.

Rural hospitals are struggling to stay open nationwide as challenges continue to grow. Recent research demonstrates that half of rural hospitals are currently operating in a deficit, up nearly seven percent over a 12-month period, the biggest jump researchers have noted while monitoring the issue.⁵ In some states, the landscape is even worse, with both Kansas and Wyoming reporting over 80 percent of rural hospitals operating in a deficit.⁵ Even for the rural hospitals that are able to stay open, many are forced to stop providing vital services, like obstetric/gynecologic (OB/GYN) care and cancer care.⁶ Since 2020, over 100 labor and delivery units in rural areas have closed, and the problem is getting worse; closures seven months into 2025 have almost reached the same number that closed in the entirety of 2024.⁷ These closures have led to less than half, 42 percent, of rural hospitals maintaining obstetrical care. While some maintain outpatient pre/postnatal care, many are unable to continue any OB/GYN services at all, exacerbating maternity care deserts and the maternal mortality crisis facing America.^{6,7} Cancer care, including screenings, treatments, and specialty care, has also faced significant closures. Between 2014 and 2022, 382 rural hospitals were forced to stop providing chemotherapy.^{8,9} States like Texas, Alabama, Mississippi, and Tennessee were the hardest hit with at least 44 percent of their rural hospitals stopping chemotherapy services.⁶

Service closures are not the only strategy that rural hospitals have adopted to keep their doors open, as nearly 60 percent of rural hospitals have affiliated with larger health systems. Although such affiliations may help some rural hospitals stay financially viable, 42 percent of rural hospitals associated with health systems continue to operate in a

deficit.⁵ Many rural hospitals must choose between private equity investment and closure. However, the choice to accept private equity investment may still result in a closure, albeit delayed a few months or years. While this delay in closure is likely to have a positive impact on communities while the hospital remains open, in the long term the eventual closure may harm the community further due to additional debts and/or increased difficulties in reopening the hospital. Investors often focus on buying hospitals for low prices and reaping any available profit before deeming the hospital financially unviable and closing their doors, known as a “buy and bust” model. While this can prove to be quite lucrative for the investors, it puts profit above people and negatively impacts rural communities when they lose one of the few, or the only, sources of health care.^{6,10} Further detail on private equity, its practices, and related AMA policy and advocacy efforts can be found in [Council on Medical Service Report 11-A-19](#), Corporate Investors, [Council on Medical Service Report 2-I-22](#), Corporate Practice of Medicine, and [Council on Medical Service Report 3-A-25](#), Regulation of Corporate Investment in the Health Care Sector.

Importantly, payment related issues are not the only source of difficulty for rural hospitals, as they also face workforce, federal designation, supply chain, and infrastructure challenges. Many rural hospitals struggle to retain or attract talent when competing with more financially stable urban or suburban hospitals that offer higher salaries, greater benefits, and/or locations viewed as more desirable. Additionally, programs designed to combat these challenges, like those that incentivize work in medically underserved areas by offering visas to International Medical Graduates or student loan forgiveness programs, are facing challenges of their own under the current Administration. Rural hospitals also face challenges such as disrupted supply chains and unstable infrastructure, especially when attempting to implement telehealth. In order to maintain services or stay open, some hospitals have explored alternative designations, like Rural Emergency Hospital (REH), which offers an allowance for the hospital to focus on emergency and outpatient care. However, designations like REH can be challenging to implement in a manner that ensures that patients have access to high-quality and physician-led care. Overall, the situation in which many rural hospitals operate is fraught with challenges that are not limited to payment models. As such, the Council intends to initiate a future report on these issues.

RURAL HOSPITAL PAYMENT

Rural hospitals face distinct challenges in that payments often do not cover the actual cost of providing services. While the mix of payers is generally the same for rural hospitals as it is for urban hospitals (i.e., traditional Medicare, Medicare Advantage, Medicaid, and private plans), rural hospitals tend to serve a greater portion of Medicare and Medicaid beneficiaries.¹¹ Payer mix is even more important for rural hospitals due to the distinct expenses brought forth by delivering services in remote areas to smaller groups of patients. All hospitals, regardless of setting, have a fixed cost necessary to provide services (e.g., staff, capital equipment). Since rural hospitals have lower patient volumes, this leads to higher per-patient cost to maintain basic services.^{5,6,11} Therefore, a payment that sufficiently covers a patient in a higher volume setting likely does not cover the full cost of treatment in a rural setting.¹¹ More detail about payer-mix and distinct payment challenges in rural settings can be found in [Council on Medical Service Report 9-A-21](#), Addressing Payment and Delivery in Rural Hospitals, and [Council on Medical Service Report 6-I-23](#), Rural Hospital Payment Models.

Recent estimates show that Medicare beneficiaries make up about 20 percent of rural hospital patients.¹² While this could be seen as problematic for non-rural hospitals, Medicare often is the most advantageous payer as its relatively higher payment rates offset the higher costs of care distinct to rural settings. A higher rate of Medicare beneficiaries is particularly advantageous for rural hospitals designated as Critical Access Hospitals (CAHs), defined as those located 35+ miles from the nearest full-service hospital and have 25 or fewer inpatient beds. In these settings, payment for traditional Medicare beneficiaries is 101 percent of the reasonable cost for the majority of patient services.¹³ However, not all rural hospitals are eligible to be designated as a CAH, and even for those that are, increased Medicare payment rates are often not enough to cover deficits from other payers.^{5,13,14} Although rural hospitals frequently lose money when providing care for Medicaid beneficiaries, some states have worked to lessen this gap. Medicaid provides supplemental payments to rural hospitals, covering part of the difference between what Medicaid pays and what Medicare would have paid for the same service.^{5,6} The impact of Medicaid has grown as 41 states have adopted some form of Medicaid expansion, thereby increasing the number of beneficiaries served at rural hospitals.¹⁵ Importantly, rural hospitals, along with much of the health care system, are likely to be impacted by the recently passed [One Big Beautiful Bill Act](#) (OBBBA). Further discussion of the anticipated impact of this legislation can be found later in this report. Similar to Medicaid, private payer rates to rural hospitals are generally less than the cost of the services provided. However, unlike Medicaid, there is no subsidy to make up for the lower payment rates.^{5,6}

Medicare Advantage (MA) has become a particularly problematic payer for some rural hospitals. MA plans have grown significantly over the past few years and seem to be gaining popularity even more quickly among rural populations. Estimates show that since 2015 the percentage of rural Americans enrolled in MA has increased 22 percent.¹⁶ Recent research has demonstrated that MA plans pay approximately 90 percent of what traditional Medicare pays for the same services, as MA plans do not follow cost-based payment as traditional Medicare does.¹⁷ Some states have reported collected payment rates for rural hospitals as low as 35 percent among MA beneficiaries.⁵ The lower payment rates are problematic as the financial protections for rural hospitals and CAHs provided via traditional Medicare do not apply to MA plans.^{5,16} In addition to payment issues, many MA plans apply prior authorization and other utilization management options at a greater rate than traditional Medicare. Greater use of utilization management by these plans results in increased administrative challenges for the hospitals providing care. Both payment rates and administrative burden are even more challenging for small independent rural hospitals as they lack the leverage that larger systems have in negotiating with MA payers.^{6,18,19}

These payment issues are further exacerbated when patients are not insured, a problem more commonly faced by rural hospitals, leading to substantial amounts of uncompensated care that financially struggling hospitals must absorb. Unfortunately, it has been projected that passage of the OBBBA will likely lead to 10+ million Americans losing health insurance coverage, furthering the pressure on rural hospitals to provide uncompensated care.²⁰ Estimates indicate that many rural communities will face significant hikes in insurance premium costs across all payer types. Specifically, it is anticipated that in 32 states rural residents will face disproportionate hikes in their out-of-pocket premiums. It is projected that residents will experience an average 107 percent premium increase, compared to 89 percent for urban residents, in addition to the national median increase of 18 percent for private health plans. Additionally, rural residents who obtain coverage through the Affordable Care Act (ACA) Marketplace will experience 28 percent higher increases than urban residents. This is particularly problematic for rural communities, and the hospitals in these communities that provide care, as these communities rely more heavily on ACA Marketplace plans to obtain health insurance.²⁰ Further, it is likely that the work requirements outlined in the OBBBA will lead to additional disproportionate impacts on rural communities. It is anticipated that due to the additional challenges around available rural employment and/or increased challenges around coverage redetermination in rural communities, many rural residents who are eligible for coverage will end up losing coverage.²¹ These specific concerns, paired with general OBBBA coverage losses, have the potential to lead to a significant worsening of the landscape of rural health care and increased financial stress on already vulnerable rural hospitals.

During debate prior to passage of the OBBBA, many legislators voiced particular concern as to the impact that it could have on rural hospitals. As a result, a \$50 billion “rural health transformation program,” generally referred to as the “rural health fund” was included in the final language.²³ This fund is designed to be implemented by states over five years beginning in 2026. Half of the funds are to be divided equally between states that have Centers for Medicare & Medicaid Services (CMS) approved applications. The other half of the funds are to be used at the discretion of CMS based on a formula that takes into account the state’s rural population and need.²⁴ Once distributed to the state, funds should be used for activities such as improving access to hospitals and providers, improving health outcomes, enhancing the workforce, and increasing the use of emerging technologies.^{23,24} While this rural health fund seems to be promising, it is unequivocally underfunded. Experts estimate that rural hospitals will lose \$137 billion over ten years, meaning that the rural health fund only makes up about 37 percent of losses. Even with the rural health fund, rural hospitals are anticipated to lose \$87 billion over the next decade.^{23,24} This revenue loss comes primarily through the number of individuals that will lose Medicare, Medicaid, and ACA Marketplace plan coverage as portions of the OBBBA take effect. The legislation does not outline the specific criteria that CMS will use to evaluate the applications, nor which state agencies are intended to complete the application and manage the funds. Although it is anticipated that State Offices of Rural Health will play a role, the current administration has voiced intention to cut funding for these offices, leading to uncertainty as to the application and fund management.²⁵ The ambiguity of the rural health fund means that rural hospitals may not end up actually receiving the full funds. Further, states are given the ability to direct funding towards urban and suburban settings, with the approval of CMS.^{23,24} Additionally, the legislation does not define “rural,” meaning that states and/or CMS could potentially apply the term however they wish. While the impact of this legislation is yet to be determined, leaders of rural hospitals and those that study them have voiced significant concerns that the OBBBA will exacerbate current problems and may accelerate the rate of closures.^{23,24,25}

ALTERNATIVE RURAL HOSPITAL PAYMENT MODELS

In recent years, a number of programs and models have been proposed and/or evaluated to assess how well they support rural hospitals and improve overall community health. Many programs utilize one or more funding models,

often focusing on patient-centered, standby capacity, or global payment models. Some experts suggest that a relatively simple fix would be allowing for greater state flexibility as to which hospitals can be designated as a CAH, such as was available until 2006. With increasing numbers of rural hospitals at risk of closure, legislators have started to explore reimplementing this flexibility through bipartisan legislation, the [Rural Hospital Closure Relief Act of 2025](#). Alternatively, the Health and Human Services Secretary could choose to temporarily reestablish this flexibility to allow states to give this designation to struggling rural hospitals.⁵ There are currently several federal programs and initiatives designed to support rural hospitals, such as Medicare Rural Hospital Flexibility, Small Rural Hospital Improvement Program, and Rural Hospital Stabilization Program. Additionally, through a variety of funding sources like state grants, CMS Innovation Center, and CMS Quality Initiatives, a number of novel payment models have been tested. Many of these payment models relay upon a type of lump sum payment, like a hospital global budget. These rates are generally set based on the hospital's historical net patient revenue with some models building in appropriate adjustments, such as inflation. A more detailed history of existing rural hospital payment programs and the principles upon which these novel models are based can be found in [Council on Medical Service Report 6-I-23](#), Rural Hospital Payment Models.

One model that has been assessed in recent years is the Pennsylvania Rural Health Model ([PARHM](#)), which aims to transform rural hospitals by implementing hospital global budgets. The model includes 18 hospitals, five of which are designated CAHs, and six payers. It uses hospital global budgets that are paid on a biweekly basis, set using Medicare Fee-for-Service (FFS) rates, and adjusted for inflation and service changes.²⁶ While PARHM global payments exceeded the FFS rates that would have been paid in a more traditional payment structure, both hospitals and payers reported that financial unpredictability was not fully mitigated. Concerns regarding a lack of specific fund allocations and potential reconciliation payments were cited as reasons that the global payments did not support full financial stability. However, hospitals did report some improvements in the model's goal to promote community health. Specifically, there were incremental improvements in quality of care, population health of communities served, and greater community collaboration and follow-up care for those experiencing substance use disorders (SUD).²⁷ Hospitals participating in this model were able to implement partnerships with community organizations to improve case management for those dealing with SUD.

Experts at the [Texas Organization of Rural & Community Hospitals](#) have expressed that with some changes, PARHM could be a significant improvement for many rural hospitals. Evaluators working on the model suggest that greater financial stability could be secured with some targeted changes to the program. Specifically, increasing technical assistance, developing guardrails around the magnitude of settlement payments, and aligning incentives with value-based care models could all lead to more accurate financial forecasts.²⁴ Importantly, many hospitals in this model cite concerns with reconciliation payments as a major issue in gaining financial stability.²⁷ In order to ensure that rural hospitals are not only able to reach financial stability, but maintain financial stability, it is essential that any payer reconciliation is clear, fair, and predictable.

Similar to PARHM, a model piloted in Maryland, the Maryland Total Cost of Care Model ([MD TCOC](#)), relied on global budgets to improve quality of care and population health. However, this model was slightly different in that it focused on all-payers, instead of hospital based, global budgets.²⁸ Additionally, MD TCOC incorporated primary care into the model, citing the need for preventive care in addition to acute care.²⁷ In this model, hospitals were paid a fixed amount each year, adjusted annually for quality and untethered from patient volume.

Evaluation of the MD TCOC model demonstrated initial decreases in Medicare spending, lessened hospital admissions, and a reduction in health disparities across communities served.²⁸ Specifically, the model saved the state of Maryland approximately \$689 million in the first three years after implementation. Evaluators found that incentives provided via global budgets created improvements in quality measures and lowered hospital admissions. Importantly, this model relies on improvements in primary care, which are essential for maintenance of many of the mentioned outcomes.²⁹ If this model were to be implemented in a rural setting, this reliance on primary care could be problematic should patients have difficulty accessing care. However, should rural patients be able to access primary care the outcomes from this model indicate it could be promising for rural communities.

Another model that included all-payers is the Vermont All-Payer ACO Model ([VTAPM](#)). This model differed from MD TCOC in that it utilized Accountable Care Organizations (ACOs) to incentivize broad system transformation to decrease spending and improve population health. Eight hospitals and one ACO participated in the evaluation, which yielded mixed results.²⁸ This model was successful in that avoidable hospitalizations were decreased as there was an increase in collaborative approaches to address chronic health and SUD diagnoses. However, there were significant

challenges with scaling the value-based care model, leading to questions about the feasibility of the model on a state-wide or national scale. Additionally, many participating hospitals reported challenges with the increased administrative burden that accompanied this model. A number of rural CAHs opted out of participation, citing an inability to handle the anticipated increases in administrative burden.^{30,31} Regardless of hospital setting, physicians and other providers who participated in the VTAPM reported both greater understanding and more support for value-based programs after participation.³⁰ While this model did highlight some of the challenges that can come with implementing new payment models, such as educational and administrative burdens, it is possible that with appropriate technical support and funding a similar program could be scaled to support rural hospitals.

While the three aforementioned models focus on individual states, the States Advancing All-Payer Health Equity Approaches and Development ([AHEAD](#)) model is intended for nationwide implementation. While this program has not yet been implemented, it aims to increase quality of care for communities via hospital global payments and a number of non-hospital-based strategies, like cooperative funding and primary care alignment.³² To support hospitals, the AHEAD model will provide participating hospitals with global budget payments based on Medicare FFS payment rates and adjusted for inflation and changes in community population and provided services. This program will be tested in up to eight states or territories with over 10,000 Medicare Part A and Part B beneficiaries.³² Regardless of the type of model implemented, it is essential to ensure that appropriate investments are made upfront so that rural hospitals are able to establish the model without undue financial burden.

AMA POLICY

There is a robust body of AMA policy to address both rural health in general and the viability of rural hospitals. Broadly, Policies [H-465.997](#) and [H-465.994](#) outline the AMA's stance on rural health disparities and efforts to work toward improvement in access and quality of rural health care both independently and in conjunction with relevant state medical associations and national medical specialty societies. Specifically, [Policy H-465.982](#) focuses on AMA support for states to monitor and work with respective state governments to implement rural health demonstration projects. [Policy H-465.986](#) outlines AMA efforts to disseminate and support states in disseminating materials and evaluation regarding Rural Health Clinics and their certifications. Additionally, [Policy H-465.989](#) outlines AMA efforts to monitor and address the impact of billing restrictions on rural health providers and hospitals. Finally, [Policy H-465.980](#) addresses the need to ensure that health networks in rural communities are robust enough to support the population needs.

In addition to policy on general rural health, the AMA has an existing body of policy to address the challenges facing rural hospitals. For example, [Policy H-465.990](#) specifically addresses AMA support for legislation to reduce financial burdens on small rural hospitals in order to ensure they remain open and accessible to the communities they serve. Policies [H-465.999](#) and [D-465.999](#) address the complications involved with the certification rural hospitals can face when becoming a part of federal programs. Policy H-465.999 addresses Medicare rural hospital certification while D-465.999 addresses certification for CAHs. Finally, Policies [D-190.969](#) and [D-465.998](#) address AMA efforts to monitor and address payment and service delivery in rural hospitals.

DISCUSSION

Rural hospitals are absolutely essential to the nearly 20 percent of Americans that live in rural communities. These hospitals literally serve as a lifeline to their communities by providing critical health care services and significant economic support. Research shows that the majority of rural hospitals are operating in a deficit and many are at significant risk of closure. Further, many rural hospitals have needed to stop offering essential services, like OB/GYN and cancer care, in order to remain financially viable. The closure of these hospitals and elimination of services only exacerbates the existing health disparities for rural communities. Rural hospitals face low patient volume, which paired with fixed costs of services, leads to higher per-patient cost. As a result, the payments from many plans are not adequate to meet the actual cost of services provided. While there are some programs and subsidies through Medicare and Medicaid, this is not enough to make up for the deficits caused by other payers, especially MA plans. Recently passed legislation, OBBBA, is predicted to accelerate the struggle that many rural hospitals are experiencing. Although this legislation does include a substantial rural health fund, it is estimated that the fund will only account for about one-third of the lost revenue for rural hospitals. Accordingly, it seems likely that the financial uncertainty facing many rural hospitals will continue without the development and implementation of additional strategies.

As discussed in this report, multiple alternative payment models have been explored with the intent of creating a more financially sustainable system for rural hospitals. While none of these models have proved to be flawless, each has demonstrated potential positive changes that could be made. Paired with existing research, these models have demonstrated the importance of fixed cost payments for rural hospitals. When rural hospitals are able to rely on a predictable set payment, they are better able to plan and forecast in a manner that can lead to long-term financial stability. This is essential for rural hospitals, as patient volumes are typically not high enough to justify hospital fixed costs. Additionally, it is important to ensure that payment rates for variable services, which are defined as those that change in amount or frequency (e.g., materials), are fair and cover the expenditure. While this is not a distinct need for rural hospitals, it is particularly important as rural hospitals work towards financial stability. Finally, these models demonstrate the need to ensure that hospitals maintain affordability and high-quality care for their patients.

Consistent with several of the lessons learned from these models, the Council recommends the adoption of new policy outlining minimum standards for alternative payment models suitable for rural hospitals. These standards outline that, at a minimum, alternative payment models for rural hospitals should cover fixed costs, include adequate variable payment rates, incorporate affordable patient cost-sharing, and deliver high-quality care. To reiterate and expand upon AMA commitment to the importance of rural hospitals, the Council recommends the adoption of new policy that outlines ongoing efforts with interested national medical specialty societies and state medical associations to investigate novel payment models and support educating communities on promising models. Additionally, to work towards ensuring that funds allocated for rural hospitals are used for their intended purposes, the Council recommends the adoption of new policy.

Further, the Council recommends minor amendments to [Policy D-465.999](#) to request the reintroduction of the “necessary provider” designation. To address the new and growing impact of MA on rural hospitals, the Council recommends that [Policy D-465.998](#) be amended by the addition of a new fifth clause supporting not only education around MA plans in rural settings but also encouraging all payers, regardless of type, to provide adequate payment to rural hospitals. Additionally, the Council recommends that the second clause of [Policy D-190.969](#) be rescinded as it has been accomplished by this report. Finally, while the Council intends to initiate a future report focused exclusively on non-payment model challenges facing rural hospitals, in the interim a number of reaffirmations are recommended. Specifically, the Council recommends the reaffirmation of Policies [H-465.994](#), [H-465.982](#), and [H-465.997](#) which collectively work to improve rural health via telemedicine, innovative workforce challenges, managed care, as well as the creation and implementation of community-based solutions.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) supports the following minimum standards for alternative payment models to rural hospitals in order to enhance their financial sustainability and ensure access to care:
 - a. Fixed Cost Payment: Rural hospitals should be paid an agreed upon and fixed sum delivered on a predictable schedule that is not tied to patient volume.
 - b. Adequate Payment Rates: All payers should ensure that payments made for variable services are adequate to cover the full cost of care provision.
 - c. Patient Cost-Sharing: Any out-of-pocket payments made by patients should be reasonable and affordable.
 - d. Accountability and Transparency: Care delivered should be of high-quality, evidence-based, and part of a physician-led team.
 - e. Administrative Simplicity: Models should minimize administrative burdens.
2. That our AMA 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 physicians, non-physician practitioners, and patients on alternative payment models for rural hospitals.
3. That our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care.
4. That our AMA amend Policy D-465.999 by addition and deletion to read as follows:

CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION, D-465.999

Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) ~~opposes the elimination~~ support the reintroduction of the state-designated Critical Access Hospital (CAH) “necessary provider” designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

5. That our AMA amend Policy D-465.998 by addition to read as follows:

ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS, D-465.998

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.

6. That our AMA reaffirm Policy H-465.994 which outlines support for continued work with relevant and interested stakeholders to research, report, and improve rural health through strategies including telemedicine and innovative workforce strategies.
7. That our AMA reaffirm Policy H-465.982 which encourages states, and ensures AMA support, to support efforts related to managed care in rural settings.
8. That our AMA reaffirm Policy H-465.997 which outlines support for local and federal efforts to improve rural health with initiatives that are holistic and community-based.
9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this report.
10. That our AMA reaffirm Policy H-290.951.

Fiscal Note: Minimal

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**Council on Medical Service Report 3-I-25
Payment Models to Sustain Rural Hospitals
Policy Appendix**

Rural Hospital Payment Models, D-190.969

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM). (CMS Rep. 6, I-23)

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. (CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 6, I-23)

Access to and Quality of Rural Health Care, H-465.997

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

Improving Rural Health, H-465.994

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

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

Rural Health, H-465.982

1. Our American Medical Association encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations.
2. Our AMA encourages state associations to work with their respective state governments to implement rural health demonstration projects.
3. Our AMA will provide all adequate resources to assist state associations in dealing with managed competition in rural areas. (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23)

Rural Health, H-465.986

1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well.
2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics and transmit the result of such evaluation to their members.
3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. (CMS Rep. A, A-91; Reaffirmed by CMS Rep. 8, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

Rural Health, H-465.989

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants. (CMS Rep. K, A-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 3, A-15)

Elimination of Payment Differentials Between Urban and Rural Medical Care, H-240.971

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population. (Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20)

Rural Community Health Networks H-465.980

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community; (2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management; (3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined; (4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and (5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. (Sub. Res. 721, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17)

Closing of Small Rural Hospitals, H-465.990

Our American Medical Association encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care. (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

Certification of Rural Hospitals for Medicare, H-465.999

The AMA (1) urges the Secretary of HHS to reassess the regulations prescribing conditions of participation and to adopt a more realistic and humanitarian approach toward certification of small, rural area hospitals, and (2) recommends that state medical associations and state licensing and certifying agencies establish and maintain close surveillance of the certification and accreditation problems of small hospitals. (Res. 42, A-68; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18)

Critical Access Hospital Necessary Provider Designation, D-465.999

Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (Res. 102, A-14; Reaffirmed: CMS Rep. 01, A-24)

Enhancing Rural Physician Practices, H-465.981

1. Our American Medical Association supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. (CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Appended: CME Rep. 3, I-21; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 215, I-24)

4. PAYMENT FOR BIOSIMILARS

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policies D-110.987, H-100.940, H-110.956, H-110.959 and H-125.972

At the 2025 Annual Meeting, the House of Delegates referred Resolution 103, “Inadequate Reimbursement for Biosimilars,” which was sponsored by the American Society for Gastrointestinal Endoscopy, the American College of Rheumatology, and the American Gastroenterological Association and asked the American Medical Association (AMA) to:

Work with stakeholders to advocate for legislation that amends section 1847A(c)(3) of the Social Security Act to remove manufacturer rebates from the average sales price (ASP) payment structure for biologics.

The following report discusses the history and adoption of biosimilars in the United States (U.S.) as well as existing and potential alternative payment structures and their impacts. Additionally, this report reviews AMA policy and advocacy on the topic and offers recommendations in line with Resolution 103-A-25.

BACKGROUND

A biosimilar drug is a type of biologic that is similar to a Food and Drug Administration (FDA) approved branded biologic, or reference medication. Biosimilars are produced by living organisms and are required to have no meaningful clinical differences in safety, potency, or purity from a reference medication.¹ While similar to the idea of generic versus branded medications, biosimilars differ in that they are not an exact copy of the branded reference drug but rather have slight differences in the chemical makeup from the reference medication.^{1,2} Biosimilar adoption in the U.S. was initiated later than the European market, with the first U.S. biosimilar gaining FDA approval in 2015, nine years after introduction in European markets.³ Biosimilar adoption in the U.S. was relatively slow for the first five years with only nine drugs on the market by 2020. However, the last five years have shown relatively significant growth in this market with 72 biosimilars FDA approved as of July 2025.^{3,4} While recent years have shown growth in the U.S. biosimilar market and adoption, estimates still only place usage around a quarter of the overall market share.⁵ This is particularly important, as biosimilars provide a potential opportunity for significant savings for patients, providers, and payers. Biologics are exceptionally expensive, often the most expensive drugs available, and cost the U.S. health care system over \$250 billion in 2024.^{5,6,7} More specifically, recent reports have found that biologics make up about 46 percent of all pharmaceutical spending in the U.S. but only represent two percent of US prescriptions.^{5,7} Biosimilars are a much cheaper alternative that can produce similar clinical outcomes at a fraction of the cost. For example, in 2023 biosimilar usage saved over \$12 billion with only 57 approved medications. Additionally, research has demonstrated that the adoption of biosimilars has increased patient access to treatment.^{6,7}

While there is no single direct cause for the initially slow uptake of biosimilars in the U.S., it seems that patient and physician hesitancy, oversight/regulation, and a lack of insurance coverage have contributed significantly. Specifically, both patients and physicians have voiced concerns regarding the safety, efficacy, and immunogenicity of biosimilars. However, research suggests that educational campaigns may be successfully dissuading these concerns.^{8,9} Additionally, regulations and legislation around biosimilars and their adoption/approval process may have initially slowed the uptake.¹⁰ However, through the [Patient Protection and Affordable Care Act \(ACA\)](#) Biologics Price Competition and Innovation Act, Congress passed an abbreviated licensure pathway in order to encourage increases in biosimilar approval in the U.S. through a more efficient approval process.¹¹ In addition to federal regulation, the majority of states have passed legislation allowing for the automatic substitution of biosimilars for a prescribed reference medication by a pharmacist. Importantly, in these states, physicians are able to prevent automatic substitution by indicating that the prescription be “dispensed as written.”¹⁰ [Council on Medical Service Report 4-I-24](#), Biosimilar Coverage Structures, presents a detailed review of patient and physician attitudes towards biosimilars and the related legislative and regulatory history.

BIOSIMILAR COVERAGE

In addition to the aforementioned barriers to adoption, biosimilar coverage has proved to be a significant roadblock to increasing use. Payers have historically not incentivized patients or physicians to utilize biosimilars and in many cases actually incentivized the use of the more expensive reference medications.⁸ It seems that this incentivization is primarily done through rebates offered by manufacturers, typically via negotiations done by pharmacy benefit managers (PBMs).¹¹ It is hypothesized that due to the higher list price of biologics, payers are able to negotiate greater rebates, making that medication, rather than the biosimilar, more financially lucrative for the payer.^{5,11} As a result, payers may not include biosimilar medications on preferred formulary tiers or may deny coverage altogether. However, these rebates are rarely, if ever, passed along to the patient, resulting in higher patient out-of-pocket (OOP) costs and, in many cases, physicians being influenced to prescribe based on the financial incentive to the payer and/or PBM.^{5,6,11} More detailed information about PBMs practices and formularies can be found in [Council on Medical Service Report 5-A-19](#), The Impact of Pharmacy Benefit Managers on Patients and Physicians and [Council on Medical Service Report 9-A-25](#), Minimum Requirements for Medication Formularies.

Research indicates that some payers are beginning to become less restrictive regarding biosimilar coverage. A 2020 study indicated that among major private insurance plans, only 12 percent of plans placed at least half of biosimilar medications on the “preferred” tier, and significant coverage restrictions were imposed in nearly 20 percent of cases.^{8,13} Recent decisions from major payers indicate that coverage may be trending toward biosimilars, especially among higher cost biologics. For example, major payers and their associated PBMs recently announced movement away from coverage of the biologic Humira® (adalimumab) and toward coverage of its many biosimilars. Specifically, both CVS Caremark and Cigna Express Scripts, two of the three largest U.S. PBMs, recently announced that they would be removing Humira® from national template formularies and that coverage of Humira® biosimilars would be added.^{14,15} While the third major PBM, Optum Rx, still includes Humira® in its formulary, its biosimilars are placed more favorably.¹⁶ Even though Humira® and its biosimilars are subcutaneously injected drugs, and, therefore, not necessarily indicative of coverage trends among infused drugs, these examples illustrate how payers are not only increasing coverage of biosimilars but encouraging their use through diminished utilization management and/or cost sharing requirements.

Similar to private insurance coverage, Medicare and Medicare Advantage (MA) plans seem to be trending towards increased biosimilar coverage, if at a slightly slower pace than private plans.¹⁷ Research suggests that when Medicare does cover biosimilars, they are placed on the same formulary tier as the reference biologic. While this is not necessarily harmful to the uptake of biosimilars, it also does not provide an incentive for patients to switch to the lower cost biosimilar.¹⁷ Compared to traditional Medicare plans, MA plans seem to be incentivizing the switch to biosimilars via increased utilization management and/or higher cost-sharing for reference drugs.¹⁸ As a direct comparison to the aforementioned Humira® coverage example, recent research demonstrated that 96 percent of Medicare Part D plans and 88 percent of MA plans include coverage for at least one Humira® biosimilar, with the vast majority requiring the same cost-sharing and utilization management for Humira® and its biosimilars. Importantly, under Medicare coverage, non-infused biologics, like Humira® and its biosimilars, are covered under Part D while infused drugs are covered under Part B. However, these findings indicate that while most Medicare/MA plans offer coverage for biosimilars, these plans are not incentivizing the use of biosimilars as many major private plans are.^{17,19}

Importantly, federal legislation has been implemented in an effort to increase Medicare usage of biosimilars. For example, the Bipartisan Budget Act of 2018 offered extended manufacturer discounts and lowered plan contributions for biosimilars.²⁰ After the implementation of this legislation coverage of biosimilars by Medicare Part D plans increased 23 percentage points.¹⁷ Additionally, the passage of the [Inflation Reduction Act of 2022 \(IRA\)](#) introduced significant changes to the coverage of prescription drugs, such as a change in OOP caps and federal subsidies and enhanced payment for biosimilar usage.²¹ While the impact of the IRA has not been as dramatic as the 2018 budget, there has been a measurable impact on the biosimilar market. Research has indicated that 59 percent of practitioners reported their facilities had a slight or significant increase in biosimilar usage due to the increased add-on payment introduced in the IRA. However, this same study revealed that around 20 percent of practitioners reported a slight or significant decrease in usage and 20 percent of practitioners reported no change.²² While the recently passed [One Big Beautiful Bill Act](#) does not directly address biosimilars, it is likely that due to an increase of uninsured individuals, there will be a decrease in overall federal drug spending.²³ Additionally, the Trump Administration has produced two executive orders aimed at decreasing drug prices, with [one](#) specifically calling for an increase in biosimilar availability as an avenue to decrease spending.^{24,25}

BIOSIMILAR PAYMENT STRUCTURES

While biosimilar coverage has been slowly increasing by both public and private payers, the current payment structure is putting many physicians and their offices in significant financial distress. Per the [Social Security Act](#), Medicare payment rates under Part B coverage for infused biologics/biosimilars are set at 106 percent of the ASP, often referred to as “ASP 6.” Although this rate was temporarily increased for lower cost biosimilars by the IRA to an eight percent add on rate, or ASP 8, this increase is only guaranteed through the end of 2027.^{5,6,21} As outlined in legislation, ASP is calculated as the sales of a drug to all purchasers in the last quarter (“manufacturer price”) divided by the total number of units sold in the same quarter. While this seems like a relatively straightforward calculation, a number of concessions are included in the manufacturer price. Specifically, manufacturer-reported volume, prompt-pay, and cash discounts, chargebacks, and rebates are taken into account when calculating the ASP based payment rate.^{6,26} These concessions, particularly rebates, can lead to rebate “walls” (sometimes referred to as rebate traps). While not specifically intended to lower payments rates to physicians/practices, these rebate walls often impact the ASP calculation by lowering the quarterly sales prices and, as a result, lowering the payments to practices.^{27,28} These payment structures have become especially problematic for physicians when prescribing infused biosimilars. Importantly, although private payers are not required to utilize an ASP payment system for biologics/biosimilars, many choose to follow the lead of the Centers for Medicare & Medicaid Services (CMS) and utilize this payment structure.

These infused biologic medications are covered by Medicare Part B, and many private payers, under a “buy-and-bill” model, meaning that physicians/practices purchase the drug and then bill the payer after the drug is administered with payments coming quarterly via a set fee schedule.^{6,28} This means that physicians are not only responsible for prescribing the drug but also ensuring that these treatment decisions do not have negative financial implications for their practice.⁶ When assessing the financial implications of a biosimilar, physicians/practices must also take into account the acquisition, day-to-day, and administrative costs associated with the drug. For example, many biosimilars have specific storage requirements that can require costly investments on the part of the physician/practice.^{5,6} This can be particularly harmful for small practices that may have less negotiating power than larger practices or hospitals. Additionally, these small practices must find funding for the fixed costs associated with biosimilar/biologic administration with lower patient volume than larger practices/hospitals. In conjunction, while these payment models are harmful for most practices, they are particularly challenging for small practices to overcome. This payment model, as previously mentioned, can cause significant financial distress for physician practices due to impacts of net cost recovery. A quarterly payment structure is not as responsive to changes in ASP and may lead to a “lag” in payment, resulting in the purchase of a reference biologic over a biosimilar.²⁸ As previously mentioned, ASP calculations include provider discounts and rebates, resulting in actual provider acquisition costs being, in some cases, higher than the ASP. Additionally, while the add-on percentage to the ASP is intended to cover the additional costs associated with biosimilars, particularly infused drugs, many physician practices find themselves “underwater” as the actual associated costs are significantly more than the payment.^{6,27,28} In these cases, physicians/practices are faced with the decision as to whether to refer patients to hospital outpatient departments, often leading to higher patient OOP costs and more spending for the health system overall.²⁸

In order to address the issues that are often caused by the ASP and buy-and-bill payment structures, experts have offered alternatives. While some have suggested raising the ASP add-on rate, the IRA did not seem to solve the problem of physician/practices being “underwater” even though it raised the ASP add-on rate from ASP 6 to ASP 8.^{5,6,28} It is possible that raising the ASP add-on rate further could help mitigate the problem. However, because the ASP model may operate at too slow a pace to provide immediate full financial relief to physician practices, alternatives may need to be explored.²⁸ One potential alternative to ASP based payment is to move towards shared savings programs. In these programs, the shared saving of switching to a lower cost biosimilar is shared with the physician. While these programs have shown some promise in European markets, there is speculation that they may not be as effective in the U.S. unless they are implemented in conjunction with the changes to the buy-and-bill system.

Alternatively, experts, including the Office of Inspector General, have offered the use of least costly alternative (LCA) payment structures instead of ASP.^{5,6,29} Within LCA payment structures, CMS would pay 80 percent of the defined rate, set at 106 percent of the least costly biosimilar, and the patient would pay the remaining amount. Should a drug have a cost equal to or less than the LCA, the patient would pay the standard 20 percent cost sharing. However, in the case that the drug costs more than the LCA, the patient would pay the difference in addition to the traditional 20 percent cost share, with CMS payment remaining steady at 80 percent of the LCA.²⁸ While this would result in cost savings for CMS, it would likely have a harmful impact on patients that require higher cost drugs and would increase

financial risk for physicians if/when patients are unable to fulfill their cost sharing.²⁸ Additionally, due to Medicare prohibition of balanced billing, it is unlikely that LCA would be implemented successfully.³⁰ A more promising alternative may be a “blended” payment rate system. In this system, all interchangeable biosimilar and biologic products would be grouped together and paid at a weighted-average ASP 6 for all of a group’s drugs.²⁸ This would likely result not only in an increase in competitive pressure on manufacturers but also an increase in the payment rate for physicians, as the higher cost biosimilars would be incorporated into the ASP for all related biologics.²⁸

In addition to this blended payment rate system, changes and/or alternatives to the buy-and-bill system could be considered. For example, the Medicare Payment Advisory Commission has recommended the [Drug Vendor Program](#) which would allow CMS to contract with competitive third-party intermediaries to negotiate lower prices and fewer utilization management requirements. Experts posit that this type of system would not only allow for lower patient cost-sharing but also be financially and administratively advantageous for physicians.^{28,31} While there is not a clear single alternative to either ASP payment models or buy-and-bill systems, it is important that payment structures ensure both patient access to prescribed drugs and physician/practice sustainability.

AMA ADVOCACY AND POLICY

The AMA has a robust body of policy meant to ensure that prescription medications are affordable and that physicians are able to prescribe without financial penalty. [Policy H-110.997](#) supports physician involvement in prescription medication pricing and ensuring that physicians are able to prescribe the medication that is best for the patient. [Policy H-110.987](#) supports federal legislative and regulatory advocacy to reduce anticompetitive behaviors, like patent manipulation, in drug manufacturing and outlines the importance of physician support in lowering pharmaceutical costs. [Policy H-110.990](#) outlines efforts to ensure that cost-sharing and out-of-pocket costs for prescription drugs are fair and patient-friendly. Finally, [Policy H-110.959](#) outlines the importance of ensuring that drug payment methodologies do not result in physician practices being paid less than the cost of acquisition, inventory, storage, and administration of a drug.

In addition to policy designed to ensure that all prescription drugs are affordable and accessible, the AMA has policy supporting the use of biosimilar medications. [Policy D-125.989](#) supports physician autonomy in determining if a biosimilar or biologic product is dispensed to a patient and ensuring that switches from biologics to biosimilars are not done without notification and authorization of the prescribing physician. [Policy H-125.972](#) outlines AMA efforts to support physician education on biosimilars, their FDA approval process, and surveillance requirements. [Policy H-125.973](#) encourages the FTC and DOJ Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologic originators and PBMs to ensure they do not impede biosimilar development and uptake. [Policy H-100.940](#) outlines AMA support for incentivizing the use of lower cost biosimilars when it is safe, fiscally prudent, clinically appropriate, and agreed upon by the patient and physician. Additionally, this policy outlines support for eliminating acquisition costs and reimbursement disparities across in-office treatment locations and patient education on biosimilars.

In addition to the aforementioned policies, the AMA has engaged in extensive state level advocacy regarding substitution of interchangeable biosimilar biologic products since 2012. The AMA has worked with dozens of state medical associations to support state amendments to pharmacy practice acts to align with new federal definitions. For example, AMA advocated in support of new laws in [Indiana](#), [Washington](#) and [Mississippi](#). Additionally, the AMA has undertaken robust advocacy efforts to lower drug costs for patients, especially around regulation and increasing the transparency of PBMs. Specifically, over the past two years the AMA has written a number of letters to [payers](#), [regulators](#), and [legislators](#) and testified before both the [House](#) and [Senate](#) regarding regulation of PBMs. The AMA also has an ongoing grassroots campaign, [TruthinRx](#), designed to support patients and physicians in understanding and fighting the lack of transparency through education and advocacy.

DISCUSSION

Since their introduction into the U.S. market, biosimilars have faced slow adoption with incremental increases over recent years. While concerns have been expressed by patients and physicians around the safety, efficacy, and immunogenicity of biosimilars, current research and legislation suggests that support is trending towards even greater biosimilar adoption. As the biosimilar market is becoming more competitive, payers are recognizing the potential for cost-saving and adding more biosimilars to their formularies.

Greater adoption of biosimilars has the distinct ability to lower overall U.S. drug spending and, in turn, make expensive drug treatment more accessible to many Americans. However, the Council believes that it is essential that physician practices are not harmed in the process. With greater usage of biosimilars, payment structures for these drugs are becoming more important. Currently, Medicare Part B relies on an ASP 6 (temporarily ASP 8) payment structure for infused biologics and biosimilars. While this payment structure was not intended to be disadvantageous to physician practices, the speed at which the biosimilar market has been changing, coupled with the PBM system, has resulted in financial harm. Additionally, the inclusion of exceptions, such as manufacturer rebates, often cause the ASP to be even lower than the cost of acquisition. Due to the associated cost of acquiring, storing, and administering many biosimilars, especially infusible drugs, payment to physician practices may be less than the actual cost.

In order to ensure that biosimilar payment is structured in a manner that allows physician practices to be financially sustainable, the Council recommends the adoption of three new policies and the reaffirmation of two existing policies. First, the Council recommends adoption of new policy encouraging the revision of the existing ASP payment model to fully cover costs to physicians/practices. This new policy encompasses the intent of the referred resolution and allows for greater ongoing advocacy to secure adequate payment. Second, the Council recommends the adoption of new policy to support the future implementation of payment structures that are fair and comprehensive to ensure support for payment structures that maintain patient access to biologic/biosimilar drug(s), address practice administrative and acquisition costs, and incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician. Third, the Council recommends the adoption of new policy to support the calculation of ASP to mimic the “blended payment” system outlined in this report. Finally, the Council recommends that Policies [H-100.940](#), [H-110.959](#), [H-125.972](#), and [D-110.987](#) be reaffirmed, as they support incentivizing biosimilar use when appropriate, oppose drug payment methodologies that are financially harmful to physician practices, support biosimilar education for physicians and patients, and encourage accountability and transparency for PBMs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 103-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) supports the revision of the Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent the cost of drugs for the physician practice.
2. That our AMA encourages public and private payers to implement comprehensive payment structures that allow for fair and timely payment for biologic/biosimilar drugs that:
 - a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician consistent with AMA Policy H-100.940;
 - b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug through a payment rate that covers these costs;
 - c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and
 - d. Ensure that patient out-of-pocket costs are affordable.
3. That our AMA supports calculating the ASP for biologic/biosimilar drugs under Medicare Part B as the average price paid for a reference biologic and its interchangeable biosimilars adjusted by the market share of each product while ensuring payment is adequate to maintain the financial viability of physician practices.
4. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities, and patient education.
5. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies that result in physicians being paid less than cost of the drug and related clinical services.
6. That our AMA reaffirm Policy H-125.972, which supports the education of physicians on biosimilars and their involved processes as well as encourages data collection and evaluation by the Food & Drug Administration.
7. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the regulation of pharmacy benefit managers in a manner that encourages transparency.

Fiscal Note: Minimal

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Council on Medical Service Report 4-I-25 Payment for Biosimilars Policy Appendix

Prescription Medication Price Negotiation, H-110.959

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

Cuts in Medicare Outpatient Infusion Services, D-330.960

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents. (Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18)

Biosimilar Coverage Structures, H-100.940

1. Our American Medical Association supports the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician.

2. Our AMA advocates to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations.
3. Our AMA supports patient education regarding biosimilars and their safety and efficacy. (CMS Rep. 04, I-24)

Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse, H-125.973

Our American Medical Association will encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (Res. 207, A-24)

Cost Sharing Arrangements for Prescription Drugs, H-110.990

Our AMA:

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

Pharmaceutical Costs H-110.987

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

- b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
 - c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24)

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